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MEDICAID FREEDOM OF CHOICE WAIVER ACTIVITIES

HEARING

BEFORE THE

SUBCOMMITTEE ON HEALTH

OF THE

COMMITTEE ON FINANCE
UNITED STATES SENATE

NINETY-EIGHTH CONGRESS

SECOND SESSION

MARCH 30, 1984

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MEDICAID FREEDOM OF CHOICE WAIVER ACTIVITIES

FRIDAY, MARCH 30, 1984

U.S. SENATE,
SUBCOMMITTEE ON HEALTH
OF THE COMMITTEE ON FINANCE,
Washington, DC.

The subcommittee met, pursuant to notice, at 9:53 a.m., in room SD-215, Dirksen Senate Office Building, Hon. David Durenberger (chairman) presiding.

Present: Senator Durenberger.

[The press releases announcing the hearing and the opening statement of Senator Durenberger follow:]

[Press Release No. 84-122, February 27, 1984]

SENATE FINANCE SUBCOMMITTEE ON HEALTH SETS HEARING ON MEDICAID FREEDOM OF CHOICE WAIVER ACTIVITIES

Senator Dave Durenberger (R., Minn.), Chairman of the Subcommittee on Health of the Senate Committee on Finance, announced today that the Subcommittee will hold a hearing on the results of the implementation of the section 2175 waiver authority.

The hearing will be held on Monday, March 19, 1984, beginning at 9:30 a.m. in Room SD-215 of the Dirksen Senate Office Building.

In announcing the hearing Senator Durenberger noted that "In 1981, section 2175 of P.L. 97-35 attempted to increase the efficiency of Medicaid program administration by allowing States to implement innovative approaches to providing care. States were able to receive waivers of certain programmatic requirements in order to implement these approaches. Among the requirements that could be waived, one of the most controversial, was the so-called 'freedom of choice' provision. Critics of P.L. 97-35 felt that any waiver of the freedom of choice requirement would further restrict Medicaid recipients' access to health services."

Senator Durenberger also noted that as of January 31, 1984, 24 States had submitted seventy-five waiver requests under the section 2175 authority. Thirty-four of these requests have been approved. To date, the Committee has not had an opportunity to examine the effects these waivers have had on:

(1) Recipient access to services;
(2) quality of care;
(3) health care provider participation rates; and
(4) Medicaid utilization and expenditure levels.

Senator Durenberger stated that the Subcommittee is interested in hearing from the Administration in addition to State Medicaid authorities, provider groups, researchers involved in the evaluation of the projects, and recipient groups.

[Press Release No. 84-122, Revised: March 1, 1984]

FINANCE SUBCOMMITTEE ON HEALTH RESCHEDULES HEARING ON MEDICAID FREEDOM OF CHOICE WAIVER ACTIVITIES

Senator Dave Durenberger (R., Minn.), Chairman of the Subcommittee on Health of the Senate Committee on Finance, announced today that the hearing which had been scheduled for Monday, March 19, 1984 has been rescheduled.

The hearing will now begin at 10:00 a.m on Friday, March 30, 1984, in Room SD-215 of the Dirksen Senate Office Building.

OPENING STATEMENT, SENATOR DAVE DURENBERGER

We are in the midst of a revolution in our health care system. Buyers of care—whether patients, employers, insurers, HMOs. PPOs, or even government—are paying attention to price. Business is going to the health provider who delivers the best care at the best price. Its a revolution characterized by consumer choice and provider competition, and it's working!

But there are some problems. Our major government financing program for the medically disadvantaged—Medicaid—covers only a portion of the needy population. Our present system of public and private health providers picks up a lot of the slack, but now even that system subsidized financing is being threatened.

For years, we have been able to use a relatively price-insensitive hospital market to subsidize care for the disadvantaged. Hospitals that provided this care were able to build the costs into their private room rates.

But as the health care marketplace becomes more and more price-competitive, it becomes increasingly difficult for hospitals to provide care for the indigent by simply boosting the price charged to private patients. Price-sensitive health plans and patients will just take their business elsewhere.

For these—and related—reasons this Sub-Committee began last November to address the subject of the future of health care services for our country's economically disadvantaged. We have already looked at LTC and MR services and financing. Next month a major hearing will scope the entire probem by population, program and inter-governmental responsibility. A large part of the latter has been in medicaid.

The Medicaid program faces a rocky future. By 1982 Medicaid financed the care of 22 million low-income persons at a cost of nearly $32 billion. According to estimates derived from the Congressional Budget Office, the Medicaid program is estimated to grow by 132 percent between 1984 and 1992.

Given the size and importance of the Medicaid program, both the Congress and state officials have begun to look for ways to increase the efficiency of the program. In 1981, the Congress changed the Medicaid statute in a way that would allow states, through waiver authority, a new flexibility to negotiate with health care provider groups. Among the conditions that could be waived is one that requires Medicaid recipients to be free to select the provider of their choice—the so-called "freedom of choice provision.

As of the end of February, 1984, twenty-four states had submitted to the Health Care Financing Administration seventy-four waiver requests under the Section 2175 authority. Thirty-three of these requests have been approved. To date, no evaluation of these state efforts has been completed which examines the effect these waiver projects have had on: recipient access to services; quality of care; health care provider participation; and, Medicaid utilization and expenditure levels.

We realize that the states' waiver experiences are very new. The oldest program under the waiver provisions went into effect at the beginning of 1982. However, we are anxious to hear about even the limited experience states have had with the waiver experiments, and the changes that may be necessary. We expecially want to hear about the trade-offs that are inherent in the exercise of these waiver provisions—what have we gained, what, if any, have been the costs?

Some might think that the waivers inhibit the development of choice and price competition. I'm not so sure. When reimbursement levels are dropped so low that mainstream provider pull out of the program, there's not much choice. Furthermore, the thrust of the emerging competitive health system is that buyers direct business with an eye on price. If individual patients are not in a position to examine price—as is the case for many in the Medicaid program—then it may make sense for government to assume the price-sensitive purchased role.

I'm looking forward to our witnesses' reactions to all of these items, and I wecome all of you.

Senator DURENBERGER. The hearing will come to order.

We are in the midst of a revolution, starting our meetings at 9:30 instead of 10. In our health care system, buyers, employers, insurers, HMO's, PPO's, and even Government are all starting to pay

attention to price. Business is going to the health provider who delivers the best care at the best price.

It is a revolution characterized by consumer choice and provider competition, and it is starting to work. But there are still some serious problems. Our major Government financing program for the medically disadvantaged, medicaid, covers only a portion of the needy population. Our present system of public and private health providers picks up a lot of the slack, but now even that system of subsidized financing is being threatened. For years we have been able to use the relatively price-insensitive hospital market to subsidize care for the disadvantaged. Hospitals that provide this care were able to bill the costs into the private room rates, but as the health care marketplace becomes more and more price competitive, it becomes increasingly difficult for hospitals to provide care for the indigent by simply boosting the price charged to private patients. Price-sensitive health plans and patients will just take their business elsewhere. For these and related reasons, this subcommittee began last November to address the subject of the future of health care services for our country's economically disadvantaged. We have already looked at long-term care and mentally retarded services and financing. Next month a major hearing will scope the entire problem by working at the economically disadvantaged population and the intergovernmental responsibility for this population group. The medicaid program faces a rocky future.

By 1982 medicaid financed the care of 22 million low income persons at a cost of nearly $32 billion. According to estimates from the Congressional Budget Office, the medicaid program is estimated to grow by 132 percent between 1984 and 1992. Given the size and the importance of medicaid, both the Congress and State officials have begun to look for ways to increase the efficiency of that program.

In 1981, the Congress changed the medicaid statute in a way that would allow States waiver authority and new flexibility to negotiate with health care providers. Among the conditions that could be waived is one that requires medicaid recipients to be free to select the provider of their choice—the so-called Freedom of Choice provision.

As of the end of February 1984, 24 States have submitted to the Health Care Financing Administration 74 waiver requests under section 2175 authority. Thirty-three of these requests have been approved. To date no evaluation Of these State efforts has been completed which examines the effect these waivered projects have had on recipient access to service, quality of care, health care provider participation, and medicaid utilization and expenditure levels. We realize that the States' waiver experiences are very new. The oldest program under the waiver provisions went into effect at the beginning of 1982. However, we are anxious to hear about even a limited experience that States have had with the waiver experiment and the changes that may be necessary. We especially want to hear about the tradeoffs that are inherent in the exercise of these waiver provisions.

What have we gained? What, if any, have been the costs? Some might think that the waivers inhibit the development of choice and price competition. I am not so sure. And reimbursement levels have dropped so low that if mainstream providers pull out of the

program, then there is not much choice. Furthermore, the thrust of the emerging competitive health system is that buyers direct business with an eye on price. If individual patients are not in a position to examine price—as is the case for many in the medicaid program—then it may make sense for Government to assume the price-sensitive purchaser role. So, I am looking forward this morning to our witnesses' reactions to these items and other items they may have come prepared to testify to. I welcome all of you to the hearing and call our first witness.

STATEMENT OF JACK A. MEYER, RESIDENT FELLOW IN ECONOMICS, AMERICAN ENTERPRISE INSTITUTE, WASHINGTON, DC

Mr. MEYER. Thank you, Senator, and I am glad to be here. In the interest of your time, I would just like to go over a few highlights of my testimony. I know you have gone through it, and your staff has, too, so I submit it to you for the record. I will be glad to respond to any questions or commments you might have.

I think the place to start is to note that I am somewhat alarmed by the fact that the fraction of low-income people covered by medicaid seems to be edging down steadily. The program, of course, never did cover all the poor. We are now down to about 52 or 53 percent of low-income households covered by medicaid. That contrasts with about 65 percent 7 or 8 years ago. We have been cutting medicaid eligibility through restrictions in AFDC, which trigger a loss of medicaid benefits, and we have also been cutting the Federal contribution to the States. Because of those cuts in Federal contributions and soaring health costs many States have had to trim covered services. Just an example or two. In the State of Florida, there is a ceiling of $100, down from $500, on the outpatient services that the State will pay for during a year. It doesn't take long to run up $100. The State of Tennessee, a couple of years ago, cut covered hospital days from 20 to 14.

This sort of cost shifting and benefit cutting is really a very short-sighted strategy. It is all many States felt they could do at that time. At the same time, we have held down fees, and this has been counterproductive, as I argue in my testimony. The state of Florida hasn't raised its medicaid fees since 1972.

We discovered in our visits to New Jersey that this State is paying doctors under medicaid $7 for an office visit. Now, with all the paperwork and a $7 payment, the reaction of a lot of doctors is—I don't need that aggravation. The tragic result is that, in our short-sighted effort to save a few bucks by paying doctors less, we steer patients into the higher cost setting and often the inappropriate setting of wandering into an emergency room for nonemergency care.

Our research has found that there is embarrassingly little preventive care as well as primary care in medicaid, care where medicaid recipients have a case manager—a point of entry into the health care system—who can guide them through referrals and hospitalization where necessary. And this has led to haphazard selection—doctor shopping—and as I say, a lot of emergency room use beyond what you would prefer to see happen.

Now, I think freedom of choice has been something of a misnomer. It is very hard, as I am sure you realize from traveling around the country, to go around the country and say that you are against freedom of choice—how could such a thing be?

Well, I am for meaningful freedom of choice, but I think that the kind we have has protected the high-cost providers and impeded innovation. I think the real freedom of choice is when the buyers of care—whether it is the State or Federal government, or the employers and unions of this country—have the right to say we want to do business with you. We have the freedom to choose you because you are offering us an attractive benefit package for a reasonable cost, and we have the freedom of choice not to do business with you, because you are not offering an attractive package of benefits at a reasonable cost. It is just such freedom for buyers that, ironically, has been hamstrung by these so-called "freedom of choice" statutes. Now, medicaid, like medicare and the Nation's employers, must direct their patients to more cost-effective plans, and I think that prudent purchasing will bring real freedom of choice. By saving money, I might add, it will free our needy citizens from some of the benefit cuts that will otherwise continue unabated.

Instead of rewarding cost consciousness, the Government has often haggled with the medical establishment over price, all within the protective cocoon of the dominant fee-for-service arrangement. I think we have relied too much on ratesetting and entry controls—they haven't worked in arresting costs, and they have shored up the interests of the people inside against those who would gain entry and compete with them.

Primary care networks and case management models, in my view, offer an alternative to this approach of rate and entry controls. As you noted in your introductory remarks, the jury is still out on the cost effectiveness of this approach, and at AEI we are doing a lot of research which we think ultimately will contribute, along with the work of others, to the knowledge about the cost effectiveness of this approach.

But we feel that the incentives-based reforms are at least off on the right foot. They begin to provide incentives to providers of care to share in the risk and share in the rewards, and incentives for them to hold down unnecessary utilization. This has been the missing element in the price control approach.

I believe that we must offer certain protections to doctors to limit their risk, and yet put them at greater risk than they have been under the traditional medicaid package. I have outlined in my testimony some of the variations in the way risk is handled under different primary care network case management programs. Some States are contracting with hospitals, as in California, on a selective contracting basis. Others are working with doctors on primary care, creating incentives for these doctors to hold down referrals to specialists and to reduce unnecessary hospital stays.

I think that patients, like physicians, face a tradeoff. You mentioned tradeoffs, Mr. Chairman. Doctors are trading off volume for price—they will help control the utilization of services, and that will help hold down the Government's cost. In return, the doctors receive a somewhat higher fee. So, if the doctors begin to get $12 or

$14 for an office visit, or receive a case management fee for serving a medicaid patient, the State will save money on the quantity side. The State will be no worse off and maybe better off and, the doctors will want to be involved in the system.

And then, the original purpose of medicaid, which was to give low-income people access to mainstream medicine, will be fostered rather than thwarted. The ironic result of what we have done—with no intention to be sure—has been to deny them that mainstream care by eliciting these boycotts.

I think that patients make tradeoffs, too. What you are doing is saying to patients that there will be some restrictions on your doctor shopping and roaming through the community to get care in a haphazard fashion, but by the same token, you will get more primary care and more continuity of care. Some of these demonstrations involve a 6-month guarantee of eligibility even if you drop off AFDC temporarily, so that they don't go on and off medicaid. That, by the way, is an incentive to the doctors, too. They don't constantly have people coming in and out. So, patients are trading more continuity and access in return for some restrictions on their behavior. I think this is better than relying on a cost-sharing approach for medicaid. I am enthusiastic about more cost-sharing being offered to employees around the country, as you know, but I think that we have to be very careful about imposing higher and higher cost sharing on low-income people. It defeats the purpose of the program.

What I tried to do in my testimony was to highlight the problems, decisions, and challenges that a State or locality faces in order to get these new programs up and running—how do you enroll doctors, how do you set capitation rates, how do you work out fair grievance procedures and quality controls? All of these decisions are necessary. I can only report to you that the preliminary results are encouraging. It is too early to tell if these findings are definitive, but people that institute such models have noticed drops in utilization and inappropriate care fairly quickly.

I am not here to endorse these new cost containment measures, but to urge that the Congress press the executive branch to continue to investigate them.

I would like to close by saying that I am somewhat alarmed at recent reports that suggest—if they are accurate—that the Office of Management and Budget is trying to clog the pipeline that leads to waivers, and perhaps even shut down some waiver programs that have already made it through the pipeline. We have cases where the foundation community and the Government have invested millions of dollars gearing up for pilot projects. That may seem like a lot of money, but we are talking about medicare and medicaid which together, along with the States' share, total about $100 billion.

So, if we have to spend $100,000 here and $100,000 there to figure out how to get control of these two programs, I think it is money well invested. The jury must be allowed to deliberate, and I think that these freedom of choice waivers—along with the other waivers—such as the long-term care and demonstration waivers under the other sections of OBRA—represent an example of needed flexibility and experimentation. We must allow this evalua-

tion process to proceed. New initiatives have to be objectively evaluated, and then when we get the results, we should use these results to make changes in policy. Thank you.

Senator DURENBERGER. Thank you very much.

[The prepared statement of Jack A. Meyer follows:]

Prepared Statement of

Jack A. Meyer
Resident Fellow in Economics
American Enterprise Institute
Washington, D.C.

Presented to the United States Senate
Committee on Finance
Subcommittee on Health

March 30, 1984

The views expressed are those of the author and do not necessarily represent those of the American Enterprise Institute, a nonprofit research and educational institute that does not take positions on public policy issues. The author would like to thank Joel Menges, Research Associate at AEI, for valuable assistance in preparing this testimony.

Thank you for this opportunity to appear before your subcommittee to discuss the important role that freedom of choice waivers can play in improving the Medicaid program. At the outset, I would like to point out that the granting of freedom of choice waivers for Medicaid can be viewed as part of a larger trend of relaxing the rigidity of social programs. After years of insisting upon a rigid national design in joint federal-state social programs, the federal government is now beginning to allow states the necessary freedom to design and implement a variety of reforms in payment mechanisms and program administration. This is a trend which I would like to see continued and expanded.

I would point out, however, that I am very much opposed to local determination of benefits and eligibility standards for social programs, particularly with regard to the major health, nutrition, and cash benefit programs targeted to the nation's low-income households. The eligibility standards for our social programs -- who should qualify for assistance and who should be left out -- should not be determined separately in the 50 state capitols. Nor should the benefits available to these persons vary to any large extent from state to state. Aside from some small adjustments for cost-of-living differentials across states, people of equal need should receive equal benefits -- the level of income maintenance, food aid, or health care available should not hinge on the state the person happens to reside in. These determinations should transcend state boundaries, and I am concerned that this Administration's push toward decentralization -- shifting the decisionmaking from the federal government down to each of the state governments -- while laudable in most respects, might get carried too far.

What states should be allowed is ample flexibility to determine the most efficient method of getting the services to the beneficiaries. In the Medicaid program, this translates into a need to restructure the reimbursement to providers in a way that reduces cost while still assuring the recipients access to high quality health care services. The rigidity of the program's structure prior to the waivers has led to a myriad of problems, which I would like to discuss briefly.

It was initially felt that by giving beneficiaries the freedom to select their own providers, access to high quality care would be assured and Medicaid recipients could use the health care system in the same way that the rest of us do. Unfortunately, this has not been the result. Providers are not required to treat Medicaid patients, and often choose not to do so for a variety of reasons -- including low reimbursement, complicated administrative requirements, and an inability to discern whether a patient is still on the Medicaid rolls. Medicaid beneficiaries, who understandably find the program confusing, have rarely been able to locate a "family" doctor and establish the kind of physician-patient relationship that is needed for continuity of care. Instead, Medicaid recipients' use of the system is markedly different than that of the general population. It is characterized by haphazard selection and frequent changes of providers, heavy reliance on hospital emergency rooms (particulary in public hospitals, which are required to treat them), and embarassingly little use of preventive and primary care services. In essence, we have created just the two-tiered form of care that we were hoping to avoid when we designed the program.

It has also become clear that the program's design leads to unnecessarily high expenditures. The retrospective cost-based reimbursement structure gives neither providers nor recipients the

incentive to make cost-effective use of the health care services offered under Medicaid. With health costs increasing much faster than the overall rate of inflation during the late 1970s and early 1980s, and with the added pressures of cutbacks in federal assistance and diminished revenues brought on by the recent recession, states have developed a keen interest in gaining some control over their Medicaid budgets.

Inappropriate responses to the cost squeeze

Without the flexibility to restructure their programs, the states have opted for eligibility cuts, reductions in the benefit package, and/or freezes in reimbursement rates to providers. All three of these measures leave program beneficiaries worse off while leaving intact the underlying causes of the expenditure increases. While eligibility and benefit restrictions have a direct adverse effect on the beneficiaries, the payment of very low fees to physicians has an indirect, though equally adverse effect on beneficiary welfare. Florida, for example, has not increased its reimbursement rates for physicians since 1972, and many other states are paying the same rates as prevailed in the mid-1970s. Low reimbursements discourage physician participation in the program, thereby making beneficiary access to the primary care physician more difficult. Yet improved access is the program's primary objective. This under-reimbursement is also penny-wise and pound-foolish from the states' point of view, as they often wind up paying for other, more costly care, such as emergency room care.

It is just these kinds of inadequate responses to the Medicaid program's problem of cost escalation that highlight the need for a new approach, and it is the increased flexibility provided by the federal

government's waivers that have given the states an opportunity to attempt more effective reforms.

Beneficiary free choice of provider requirements have been a particularly strong roadblock to meaningful reform, as they protect waste and preclude provider competition in the program. It may sound confusing that the free choice of providers prevents competition, so let me take a ~~minute to~~ explain this assertion. In order for competition to take place, the buyer (in this case, the state) must have the power to 1) conduct business with those who provide a high quality product at a reasonable price, and more importantly, 2) to refuse to do business with those who fail to meet these criteria. Usually the buyer's freedom to choose among sellers is not subject to question. In the Medicaid program, however, this power is removed from the buyer's hands and given to a third actor -- the beneficiary. As noted earlier, this was done out of a good-faith intention to give Medicaid beneficiaries access to the same health care available to the general population.

It is now clear, at least to me, that as well-intentioned as this move was, it has backfired and should be reassessed. Many of the states which have obtained freedom-of-choice waivers are now implementing their restructured versions of the Medicaid program. These initiatives provide an opportunity to weigh the pros and cons of imposing certain provider networks on the recipients, and to compare the effects of doing so with the traditional Medicaid program structure. The American Enterprise Institute's Center for Health Policy Research has become heavily involved in just this kind of research.

As of March 21, 1984, HCFA received 76 applications for Section 2175 free choice of provider waivers, with 37 applications in 16 states receiving approval and 10 applications awaiting HCFA approval. Most of the innovations that evolved from the waivers involve primary care networks (PCNs), selective contracting for services to Medicaid beneficiaries, or a combination of these two approaches.

Primary Care Networks

Primary care networks have been formed in several states, and focus on the matching of medicaid recipients to a physician who acts as a "case manager" -- the recipient's initial point of contact with the health care system. The case manager usually provides primary care services himself, and channels patients to an appropriate specialist when necessary. This approach stresses primary care, an emphasis that is very much lacking in the traditional Medicaid program, where a strong bias toward institutional care exists. PCNs also make available to beneficiaries their "own" doctor, someone who knows their medical history and provides the continuity of care currently missing for many Medicaid enrollees.

While PCNs can restrict the group of participating physicians to those known to provide high quality, cost-effective care, free choice of provider within the group of participating physicians is allowed. Program administrators tend to make a strong effort to facilitate an informed provider choice by the recipients, and only when the recipients fail to select a provider is a physician match imposed on them. Even in this case administrators will try to match enrollees to providers in their neighborhood, and from a specialty relevent to the enrollee's needs.

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Provider reimbursement and cost containment incentives vary widely across PCNs. Some initiatives, such as Santa Barbara County in California and Jefferson County in Kentucky, pay case managers a capitated, or per enrollee, rate, placing them at risk for the services covered under that rate. Others, such as Michigan's Physician Primary Sponsor Plan, continue to reimburse according to fee-for-service. This program, however, threatens to lock out of the program any provider whose utilization patterns are deemed excessive. Preliminary findings suggest that significant reductions in the use of physician services, outpatient services, laboratory services, and radiology services have all been achieved without any noticable loss in quality of care.

Selective contracting for Medicaid services

A second kind of program which has been made possible by the freedom of choice waivers is selective contracting for services to Medicaid enrollees. Of these programs, California's contracting for hospital services is the best-known. The state annually negotiates Medi-Cal (as its Medicaid program is called) per diem rates for all hospital services. Those hospitals offering an acceptable rate receive contracts to treat Medi-Cal beneficiaries, while those without contracts are not eligible for reimbursement under Medi-Cal. The state of California obtained several waivers in order to set up the new payment plan for Medicaid, including a freedom of choice waiver. The state of California currently projects a 23 percent decrease in Medi-Cal hospital inpatient expenditures for FY 1984, relative to the prior fiscal year. The state plans to expand its contracting program to cover all Medi-Cal health services.

Contracting for the entire package of covered benefits (except for nursing home care) is a common approach under the Medicaid competition

demonstrations now taking place in six states. Many of these projects involve negotiated contracts between the state and several alternative health plans, usually health maintenance organizations, which receive a capitated payment per enrollee under which they are at risk to provide all covered services to their Medicaid patients. This approach often serves to combine primary care/case management with selective contracting, as it benefits the contracting entity to see that its patients are treated in a cost effective manner. AEI's Center for Health Policy Research is part of a research team conducting a study funded by the Health Care Financing Administration at HHS to evaluate the efficacy of these demonstrations. The six pilot projects have either just become operational or are still in the planning stages, so I cannot yet report on how well they are working. I will be quite willing to share our findings with this committee as our study unfolds over the next three years. Our first report, based on a round of site visits conducted between December 1983 and March 1984, will be completed in about two months.

The free choice of provider waiver was a necessary first step in allowing this wide variety of government-sponsored innovations to take place. Whether each individual reform succeeds or not will depend on how well it is tailored to the specific problems and requirements of the state or county in which it must operate. I am generally optimistic, however, about the prospects for both the PCN and the service contracting approaches to make some much-needed improvements in the Medicaid program. Medicaid is now riddled with difficulties: low provider participation; an over-emphasis on institutional care and concommitant lack of emphasis on primary care; an absence of incentives for cost-consciousness for providers and for beneficiaries; and rapidly

escalating overall program costs. The structural reforms which have been developed through the Section 2175 waivers address the root causes of these difficulties, and provide a sensible alternative to cutting the recipients' eligibility and benefits.

The problem with the "free-choice-of-provider" doctrine

In preserving beneficiary free choice of provider, we effectively close the door on innovation, and keep the program locked into its current ineffective and inefficient structure. It is worth noting that freedom of choice limitations are not strictly creatures of the Medicaid program, something that we are willing to impose on the indigent, but not on anyone else. They have characterized Medicare and most private health insurance policies as well. Recently, however, spiralling health care costs and health insurance premiums have led the private sector into the development of programs which steer patients toward providers who are either deemed to practice cost-effective medicine or have entered into contractual agreements to provide their services at a low cost. Preferred provider organizations (PPOs) are a rapidly growing phenomenon that place an indirect limit on free choice of provider. Under most PPOs, patient cost sharing is minimal or waived altogether if the patient seeks care from a participating provider, but more extensive if the patient goes outside the "system."

Another indirect means of limiting free choice of provider is through fixed contributions to health insurance premiums, where the employee pays the difference between the employer's contribution and premium amount. Because plans such as PPOs and HMOs are selective in their choice of providers, they are able to operate more efficiently and thus offer lower premiums (or a better benefit package for the same premium) than traditional fee-for-service plans. Fixed dollar

contributions are based on the principles of choice and power to the patient. Instead of the "less is beautiful" mentality of the regulatory controls strategy now in place (including Certificate-of-Need laws and hospital rate regulation, among others), these principles would make consumers more aware of and accountable for the financial consequences of their decisions. They are free to choose a high cost provider, for example, but must pay the difference themselves. This incentives-based approach puts the consumer into the health picture again, not so much at the point of use of the system (when cost considerations understandably seem almost immaterial to the consumer), but at the point of choosing a health care plan.

I want to stress that the consumer financial incentives that should be injected into the overall health care system are largely inappropriate for Medicaid beneficiaries. These patients often have such low incomes that even minimal cost-sharing would lead to decisions against seeking needed health care services. I am not opposed to "nominal" cost sharing under Medicaid, per se, but I am very concerned that it will lead to a steady increase in cost sharing that could vitiate the intent of this program. For the problem of beneficiary abuse of the Medicaid program (through high utilization of unneeded services), freedom of choice limits are again the potential solution, as these recipients can be "locked in" to a case manager who must authorize all care given to that recipient.

Private sector efforts to limit free provider choice have not been easily achieved. Many states have laws or regulations in place which require private insurors to offer complete freedom of choice to patients. This rigidity blocks private sector initiatives in the same way that innovations in the Medicaid program were thwarted before the

waivers were available. The Utah Health Cost Management Foundation, for example, has been attempting to install programs giving patients financial incentives to choose cost-effective providers (by establishing PPOs and other more cost conscious forms of care), but its efforts have been stymied by free choice of provider requirements. Last year, the Utah state legislature debated a measure that would permit restrictions on free choice of providers, but the bill failed to pass. By contrast, California removed its freedom-of-choice in 1982, and preferred provider organizations are being offered by private insurors.

The federal government has recently shown interest in assisting states such as Utah in their efforts to facilitate the development of innovative health care reforms. U.S. Congressman Ron Wyden of Oregon, a proponent of the PPO movement, has introduced a bill (H.R. 2956) that, if passed, would supersede any state law requiring free choice of provider. This bill parallels the Medicaid waivers by allowing reform efforts in the private sector to succeed or fail based on their own merits, and it eliminates the arbitrary sanctity of the cost-based, third party reimbursement system.

Preliminary findings and impressions

I would like to share a few very preliminary findings from the case studies of incentives-based reforms conducted at AEI. I want to stress the tentative nature of these conclusions; we will be extending and refining our work in the future and will be a part of a research team attempting to ascertain the eventual impact of financing reforms on the extent and pattern of utilization, on the cost of care, and on the access to and quality of care.

We are finding that the establishment of primary care network/case management models of health care financing is a process that takes a

considerable amount of time and careful planning. It is not possible to wave a magic wand and quickly change the incentive structure and payment system under Medicaid. The key decisions and areas in which background work must be done are the following:

1) marketing and enrollment;

2) the establishment of payment rates (e.g. capitation rates);

3) the development of a quality assurance program and grievance procedures;

4) the installment of prior authorization and utilization review programs;

5) the development of counseling procedures to facilitate informed choices by beneficiaries; and

6) the determination of the proper role of a fiscal intermediary in absorbing risk and giving the initiative a non-government flavor.

The questions of marketing and enrollment and the calculation of capitation rates are related. The most troublesome marketing problems involve the "recruitment" of physicians as "gatekeepers" or case managers. In many of the programs we have reviewed, participation by beneficiaries is mandatory, and where it is voluntary, the barriers to enrollment do not seem insurmountable. Indeed, in at least one program, the slow pace of recruiting physicians has been the chief impediment to the enrollment of beneficiaries, as there are not enough doctors signed up to whom willing patients can be assigned.

This does not mean that enrollment of beneficiaries is strictly routine. Enrollment of Medicaid recipients in alternative health plans involves coordination with the Medicaid eligibility determinations. This coordination can be hampered by the fact that Medicaid eligibility is typically handled by a state's social service department while the enrollment process falls within the jurisdiction of a state health department.

The challenge is to structure financial incentives in a way that strikes a balance between two poles -- too little risk for provider practice patterns to be altered significantly, and too much risk for providers to be induced to participate. In "marketing" to physicians, we need to set payment rates in the context of where they stand relative to fees that providers charge other patients and in relation to the quantity of care provided. We find fees under Medicaid far below fees charged to private patients. Office visits are reimbursed under Medicaid in the states we have visitied at rates ranging from $7 to $11, half (or less) of the fees charged other patients. At the same time that fees are depressed under Medicaid, the quantity of care has expanded and the pattern of utilization has been unorthodox. These trends of depressed fees and excessive use of services in a high-cost setting are not unrelated, as explained earlier. Low fees have led to physician boycotts of Medicaid and to sporadic and disorganized, rather than managed care.

Thus, it is important to note that physicians are being asked to shoulder more risk under a prospective-based payment against the backdrop of their long-standing experience with low reimbursement and considerable paperwork under Medicaid. The adverse incentives are heightened by new responsibilities facing doctors under a case management model. Case managers not only must authorize the care delivered by specialists and hospitals and have their earnings depend on the behavior of these units, but also must typically provide 24 hour "on-call" coverage for their enrollees.

States implementing case management models under waivers from HHS are responding to these physician concerns in several ways. Some offer per capita case management fees to doctors. A number of states are

experimenting with stop-loss provisions and reinsurance plans in order to limit the down-side risk facing participating physicians. And some authorities have established "withhold" amounts that hold back a portion of the actuarially-determined amount, pending acceptable cost experience, but do not make the doctors liable for amounts spent in excess of the capitation rates.

While governments are eager to increase physician participation in Medicaid, however, they are also unwilling to write blank checks to doctors or sanction unlimited referrals. In effect, government is striking a compromise in which effective reimbursement per unit -- the fee -- is raised in exchange a for more strict posture regarding utilization. In this way primary care physician revenues are maintained while, over time, the state begins to save money as care by specialists and in institutions declines somewhat.

We are finding that there is also a trade-off or compromise for patients. In return for reducing doctor-shopping, emergency walk-ins, etc., beneficiaries receive an appropriate point of entry into the health care system and a greater assurance of continuity of care. The latter is provided through guaranteed eligibility, regardless of AFDC eligibility, for a period of time (such as six months).

Finally, we are finding that there is a need for counseling to facilitate informed selection of a provider by patients who were confused about the Medicaid program in the first place. Quality assurance programs involve such activities as counseling, meaningful grievance procedures, periodic surveys of patient satisfaction, a right to switch providers if a "bad match" is made initially, and review committees with provider and consumer participation.

Concluding Remarks

Although it is too early to make authoritative judgements about the cost-effectiveness of reforms in health care finance rendered possible by freedom-of-choice waivers, preliminary findings are encouraging.

The waiver approval process often requires considerable time, and Congress should urge the executive branch to expedite the process without jeopardizing required legal review. Once the waivers are obtained, there will still be a considerable time lag until a program is operational. This lag involves both technical and political factors, as local authorities strive both to structure their plan with the proper amount of risk and to pave the way for the acceptance of that risk through negotiations with interested parties. Risk is vital to the successful impact of the program, but I am convinced that this risk cannot simply be imposed by fiat on participants who are already disillusioned and wary. Programs that are up and running today are operational in part because the local authorities engaged in careful deliberations and negotiations with a broad spectrum of interested parties in the community.

Once a program is operational, we seem to experience some immediate favorable results, as the pattern of care begins to change toward more appropriate settings and a reduction in overall utilization seems to occur. Whether these initial adjustments prove to be lasting is still an open question. The jury is still out on the long-term cost-effectiveness of managed care under waivers.

In my view, it is important that the inquiry proceed. Whether one is concerned with freedom-of-choice waivers or other waivers permitting different kinds of pilot projects and experiments, it would be a serious error to seek false and temporary economies by shutting off the waiver

approval process. The coexistence of soaring costs in public programs and a continuation of gaps in coverage and unmet needs requires that we continue the search for cost-effective finance and delivery mechanisms that assure high quality care. Today, Medicaid covers only about one-half of the people with incomes below the poverty line, and coverage for those who are eligible has been trimmed back. Thus, the inquiry into the cost-saving potential of new approaches to paying providers is by no means academic. If successful, this quest could help avert further cutbacks. Moreover, I do not suggest that only the reforms I find appealing should be scrutinized. Let us experiment with a variety of new approaches, subject them to rigorous evaluation, and then alter the government's programs accordingly when reliable evidence is available.

Senator DURENBERGER. Could you repeat the figures you gave me in the beginning about the decline in the population that have access to medicaid?

Mr. MEYER. Yes. According to figures released by the Robert Wood Johnson Foundation, about 65 percent of the low-income people below the poverty line received medicaid in 1976. The latest figure they have is about 52 percent today.

Senator DURENBERGER. OK, and are you the one that attributes that to financial cuts? Is that the way I heard your testimony?

Mr. MEYER. Yes; such cuts are part of the story. The economy is the other part. There has been an increase in poverty, and one of the things that alarms me is that we are making cutbacks against a backdrop of an increase in poverty, so the numerator is shrinking as the denominator has grown. The numerator is people served and the denominator is people in need. We have borne down very heavily on the working poor in this country, as you know, by making them ineligible for the kind of marginal welfare benefits that triggered their medicaid aid, which in many cases was more important to them than the $30, or $40, or $50 a month they might have gotten on AFDC.

GAO estimates that upwards of half a million people lost AFDC benefits; of course, not all of these lost medicaid eligibility, but many of them did.

Senator DURENBERGER. Were we doing things just fine until 1981 when we changed the work disincentive rules in AFDC? Was that when everything went to pot, and if we just went back to pre-1981, would everything be all right?

Mr. MEYER. I think not. I think where we were prior to those changes was preferable to where we are today, but in fairness to the Reagan administration, I have to say that they didn't invent the bias in our welfare system against the working poor. We have always had two categories of poor in Government policy—one being the split families headed by females, and they surely are needy, but other groups comprise the second category that falls in the cracks. This category included low-income, intact families, either with an unemployed head in about half the States that don't provide the AFDC–U program, or with a working head whose earnings fall short of the poverty threshold. Now, suppose you are in a family headed by someone working at the minimum wage, $3.35 an hour. Your household income is roughly $6,700 a year, if the earner is working a full year, a full week all the time. But the poverty line for a family of four is about $10,000; so, that family, working all year, is at least $3,300 below the poverty line. Moreover, they are paying some income taxes—not much, but I understand that burden has been going up a bit—and they are certainly paying payroll taxes out of that $6,700 and those taxes are going up all the time, as you well know. Then, at the same time as we are taxing some of their small earnings and thereby widening the poverty gap, we take away those few dollars in welfare that they were formerly getting, and that can trigger the medicaid eligibility loss.

Before the 1981 changes, I would say the effective tax rate was somewhere between one-half and two-thirds for the average female-headed family. That means that this woman could at least have a third to a half the dollars, on a net basis, that she earned for as

long as she earned it. That is not as good as I think we should have done, but it is better than where we are now. After 4 months of work—under the new laws—you lose your welfare benefits, dollar for dollar, except for a small and frozen expense allowance. As I have said, this can cause you to fall over the medicaid cliff as well. That can amount to an effective tax rate of 100 percent or more for our lowest income citizens. Now, in a society where we have taken a policy position that the tax rates everyone faced in 1981 were too high, how do we justify this tax hike for the poor? We talked a lot about work incentives and the need to hold down tax rates—and Congress, lowered the top bracket from 70 percent to 50 percent for our wealthiest citizens, and said 70 percent is too high. Well, if it is too high for the rich, it is certainly too high for the poor who would do well to get a 50-percent effective tax rate again.

Senator DURENBERGER. I wonder if you wouldn't come back into this process in about 3 or 4 months with some recommedations on how to tie some of the reforms we are talking about on the medicaid side with the whole public assistance income maintenance program.

Mr. MEYER. I would be glad to do that, and I will send you an article that I have finished—it is not yet published, but will be in a month or so—in which I have attempted to relate the changes in the health care sector to the changes in public assistance. But I would be glad to come back and discuss it, too.

Senator DURENBERGER. Let me ask you one other question that doesn't quite get to freedom of choice, but you did talk about decline in prevention. I know you know there is a sensitivity in this committee in the whole area of maternal and child health. To what extent do you see the decline in prevention in that area as well as other areas?

Mr. MEYER. There are reports of access problems of this nature from studies that have looked at the overall trends in access, including maternal checkups in the prenatal state. These studies include work by the Urban Institute, as well as a new study about to be released by GAO on the effects of 1981 program changes AFDC, and a report by the Robert Wood Johnson Foundation. I think these trends are quite alarming.

You know, here we are at the very point where the initiation of life occurs, where for pennies we could not only do a very humane act, but also a very long-term cost-effective act by encouraging these women to get at least minimal care. We should not be penny-wise and pound-foolish. The Iowa Legislature is considering a State-only measure to cover this type of preventive maternal and child health care. The question becomes how to fund it. Most States are strapped for money. So is the Federal Government. I think we need an honest discussion about whether we should have an excise tax and use the money from that to fund such coverage for those who cannot afford it. Perhaps, if we are ever successful in capping the tax expenditure for employer-provided health insurance, we could use some of the revenues for this vital need. We certainly can't afford all at once to have the Federal Government fill in all the gaps in coverage. I think this would be a good place to start.

I would prefer to start with a Federal program, but in the absence of that, I would encourage States—like Iowa—to continue to examine how they can start a modest program and how to fund it.

Senator DURENBERGER. Let me just read part of your testimony because I would like the other witnesses advice on what you identify as the key decisions and areas in which background work must be done. They are the following: marketing, which is not only a matter of marketing to medicaid eligibles, but marketing it to doctors, and you do a good job of pointing out that problem. The enrollment problem. The establishment of capitation or payment rates. The development of a quality assurance program for grievance procedures. The installment of prior authorization and utilization review programs. The development of counseling procedures to facilitate informed choices by beneficiaries. And the determination of the proper role of a fiscal intermediary in absoring risk and giving the initiative a non-Government flavor.

Having gone through that set of criteria for a workable program, let me ask you if there aren't, to your knowledge, in existence today health plans that do a lot of that work already, and if so, maybe you would describe them.

Mr. MEYER. Yes. I think there are in two senses. First of all, some existing health plans perform many of those functions, in particular prepaid plans. Health maintenance organizations, IPA's, and others have instituted some or all of these controls, and indeed, if one looks at Blue Cross, or even some commercial insurers, they are more and more beginning to get involved in these activities.

I could point you to the Santa Barbara Health Authority which began its demonstration in September 1983. I think that it is fair to say that they have put in place every one of these mechanisms, and have adjusted them as time went on. They have a grievance procedure, even though they have only been up and running 4 months—52 grievances were filed in January. They have all been disposed of one way or another, I think, except one. They also have a quality assurance program.

Santa Barbara has struggled with setting payment rates properly—capitation rates. The way they have set it up is to determine, after adjusting for age, sex, the risk of the patient, and so on, the proper level of payments to providers that approximate the average cost of serving different categories of medicaid patients. Then they essentially credit doctors' accounts for 100 percent of these rates, but only pay them 80 percent at first, holding back 20 percent, pending utilization experience. The Health Authority will observe utilization experience over the year, and if that turns out to go over the target, the doctors will lose proportioned chunks of the withheld amount. Health centers in the Santa Barbara area that are serving medicaid patients shoulder greater risk by operating under a capitation, where they are liable for any cost overruns,

What we found in Santa Barbara and also in New Jersey and Louisville, KY—where similar experiments are up and running—is that the authorities are trying to strike a balance between enough safeguards for the providers and the patients to lure them in, but not so many safeguards that it is simply business as usual—there does have to be an element of risk to save money, but risk doesn't

mean the law of the jungle either. We need to have these protections for consumers and providers so that the system works fairly.

One of my early impressions is that the gatekeeper approach and the apparatus of peer review and utilization review is probably more important than instituting an extreme amount of risk. Even in the group practice, fee-for-service environment, we may be able to save a lot of money if we start thinking differently about the pattern of care. There is an interesting study at Stanford where the Kaiser plan was compared to the Palo Alto Medical Clinic, the latter a multispecialty group practice on a fee-for-service basis. Their patterns of utilization and cost were very similar, and both were different from the regular fee-for-service sector, and one interpretation was that even though they didn't have capitation and prepayment in the group practice at Palo Alto, the process of looking over the shoulder, consultations, and authorizations made a difference.

Senator DURENBERGER. What I am trying to explore here is the notion of restoring freedom of choice, which was inherent in your statement. I am not talking about the freedom to choose your own doctor, your own hospital, whatever, but your freedom to make a knowledgeable, workable choice of a health plan that best meets your needs. And what I am exploring with you is whether or not a public authority needs to set up its own system of marketing, enrollment, quality assurance, et cetera—whether or not there aren't parts of this country where people just need to know a set of specifications so that they can find health plans that best meet their needs.

Mr. MEYER. Yes, I understand. I think a little of both, and it varies from area to area. I have found, in our studies, that simply relying on the private apparatus of choice and the existing apparatus of choice in many communities for the medicaid population doesn't seem to be enough—and that the authorities do have to go the extra mile themselves. This doesn't mean they have to do the whole job, but they can't be passive about it. They can't just send letters out. They have to bring people in. Many authorities have developed brochures, films, and counseling sessions to make the beneficiaries more aware of the relative advantages of various alternative health plans. There are a lot of areas where HMO's are active. And have a large nonmedicaid population in the metropolitan area, but have a very small medicaid-eligible enrollment. The caseworkers in AFDC simply aren't making the enrollees aware of the alternative care options.

So, as one public official told me when I was out in the field recently, we are saving 20 percent on those in an HMO, but only 10 percent of our medicaid are in an HMO so that the actual savings is only 20 percent times 10 percent, or 2 percent, and that is not enough. Public authorities have got to be more active in pointing out the advantages and disadvantages of an HMO or other plans, and bring those comparative features to the attention of recipients.

So, I do think that, without imposing plans by fiat, the authorities have to get into the information dissemination business, but I also think that they can rely on local experts, too.

Senator DURENBERGER. One of the points you make is about the coordination between enrollment and eligibility, and maybe some

of our next witnesses can tell us about that, too. You make the point that medicaid eligibility is typically handled by a State's social service department while the enrollment process falls within the jurisdiction of a State health department.

Mr. MEYER. Right.

Senator DURENBERGER. Do you want to tell us why that is a problem?

Mr. MEYER. Yes. In Santa Barbara, for instance, we found that the Santa Barbara Health Authority, which was trying to get this primary care network up and running, was at first working from an obsolete list of medicaid eligibles. They would find that they had somebody all ready to enroll in the network, only to notice that he had been dropped by medicaid several months before, and they didn't know that because there wasn't that coordination between the newly created auhority and the preexisting health department that handled recertification. The medicaid population is a mobile population with regard to eligibility, at least the AFDC, as opposed to the long-term care and disabled groups.

Thus, this can be a problem, but I think it is a problem that can be overcome through good management.

Senator DURENBERGER. OK. I don't want to keep you too long here, but would you just elaborate a little on the statement—and it is covered again in your testimony, where you talk about the cost and the quantity issue—these trends of depressed fees and excessive use of services in a high cost setting are not unrelated. Could you give us a little on that?

Mr. MEYER. Yes. We found, for instance, in our investigation in New Jersey, as I mentioned, that the State was paying doctors $7 for an office visit. Two members of my staff went out and talked to doctors in New Jersey and they got a very bitter reaction. Here was a State that was paying them $7, imposing a lot of paperwork, and now asking them to go at risk for the cost overruns for medicaid patients.

Now, I am not here as an apologist for the doctors. I have some specific criticisms of the way they have behaved. But what has happened is that in the same State there is an inordinately high amount of emergency room use by medicaid patients, as well as haphazard wandering into out patient clinics run by medical schools or others. There is nothing wrong with such clinics, but patients do not use them as a regular source of care. We haven't yet reached the ability to say *A* causes *B*, but it sure looks that way, and the attitudes of the people suggest that it is that way. We also have a lot of self-referral by patients to specialists when they may or may not have needed the specialist because they don't have the internist, the GP, the pediatrician there ready to help them, to guide them through the system.

This pattern of sporadic and high-cost care is showing up consistently in the medicaid program. So I argue that we have been pennywise and pound foolish. And if somebody checks into an emergency room for an hour with the flu, they can run up a bill of a couple of hundred dollars, as opposed to that $7 for an office visit to a doctor. Maybe if we had made it $14, they would have had an office to go to, and could be told that you have the flu, here are

some things to take, go home and take care of yourself, and if it doesn't get better, call me. And that is happening again and again.

Of course, there are cases where emergency care is needed, and you have to be careful here not to discourage those. But then, when you get some emergency rooms shutting down, it is almost as if that woman with a couple of kids on AFDC has no options any more. What some studies have found—including the Urban Institute Report—is that, in fact, there is another effect of our policies that I haven't mentioned as much—some people are just staying home when they are sick, and that is very frightening.

The GAO report deals with this, too. I can't release their findings for them, but I have been an advisor to that study, and I know they are about to release it. I would just say that they—along with the Robert Wood Johnson Foundation—have some alarming findings about the proportion of people who report, at least, that they have stayed away from needed care because they could not afford it. The incidence of this care-avoidance appears to be going up, and I think that we are squeezing these people, and yet not changing the very financial structure that is blowing the cost apart at this point.

Thus, I am arguing for a two-prong strategy. Let's stop wringing their necks, first of all, and second, through these freedom of choice waivers and others, let's start experimenting with a new financing system. Then, I think we can save money without putting the burden on the backs of those who cannot afford it.

Senator DURENBERGER. What is the question I should ask Carolyne Davis when she gets here about expediting the waiver process?

Mr. MEYER. Well, I think that the department has done a pretty good job in their own area of responsibility, but I think you could ask her about the pipeline for approving new waivers. You cited numbers that were almost identical to ones in my testimony about accepted applications, but there are also a lot pending. The main inquiry I would direct to her involves the relationship between OMB and the administration on one hand, and HHS, on the other; The department could probably move a little faster on waiver approval, but that is always true. I think they are doing a reasonably good job. I think the problem is that at OMB they seem to be chasing a different sort of goal than long-term structural reforms, and I think they are locking horns with HHS. I think that maybe the Congress should investigate the OMB approach to waivers, too, and what rationale they have for their posture.

Senator DURENBERGER. OK. One thing you don't have to respond to, Jack, since we are running out of time, but you made some comnents about the impact of State rate setting, and I would appreciate your putting some thoughts together on that. I met yesterday with the chairman of the National Governors Association, and he was telling me how in his State they want to probably move in that direction. And I told him that he was all wrong, but maybe you can put some of your own thoughts on how you handle both the cost and access problems. A lot of people in his State have apparently come to the conclusion that some sort of artificial rate-setting process is the only way to hold down the costs.

Mr. MEYER. Yes. It does promise a quick fix, and it has enormous appeal, and these models are well intentioned. My own reading of

the evidence is that the savings are either nonexistent or relatively small, and the cost of achieving those savings in terms of the viability of our hospital sector is quite high. In fact, it is a relevant question because I think one of the reasons why we have to talk about freedom of choice waivers and primary care networks and all these innovations that aren't quite as sexy as rate setting is that the burden is on people like me, who are critical of rate setting, to come up with an alternative.

And I think there is an alternative, but as I tried to highlight in my testimony, I can't promise any overnight results. So, we have got to be a little patient, too.

Senator DURENBERGER. OK. Thank you very much. I appreciate your testimony.

Our next panel is a panel of State medicaid officials. Sharon Marcum, deputy director, Missouri Department of Social Services; Paul Allen, director of Medicaid Services Administration, Michigan Department of Social Services; Katie Morrison, administrator, Division of Health, Wisconsin Department of Health and Social Services; and Sharon A. Wasek, director, Division of Health Care Financing, Utah Department of Health.

Welcome. Let me thank all of you for coming. For some reason or other, we always get in these regrettable situations where people come from all across the country and make very brief statements, and we don't spend as much time with you as we should. Today is one of those days where, thanks to some disagreements over foreign policy related to a nearby region of the world, we are going to have to spend some votes. Since you don't see a lot of my colleagues here today, this process is going to have to be somewhat expedited, which means that if each of you will keep your remarks as brief as possible, but get to the point. You came a long way to share some thoughts with us, and your written statements will be made part of the record. Your ongoing involvement in this process will be much appreciated. This is not a one-time shot for any of you.

So, thank you, and we will start with Sharon Marcum.

STATEMENT OF SHARON MARCUM, DEPUTY DIRECTOR, MISSOURI DEPARTMENT OF SOCIAL SERVICES, JEFFERSON CITY, MO

Ms. MARCUM. Thank you, Mr. Chairman. I am pleased today to give you a report about the Missouri prepaid administration project. This approach, we believe, is a good example of responsible use of Federal flexibility. The 30,000 AFDC recipients in Kansas City will choose among six prepaid health plans or a physician-sponsored program. Once a choice has been made, the recipient will be required to receive all care and have all necessary referrals made by the provider of choice. To date, over 7,500 clients have made this choice, with 77 percent choosing a prepaid health plan and 23 percent choosing a physician-sponsor. Key elements of this project include a wide range of choices being provided to the AFDC recipient. Prepaid health plans are being offered by two neighborhood health centers, two federally qualified HMO's, and two hospitals—a public hospital and a teaching hospital. In addition, the pri-

vate practicing individual physician has been retained as a choice through the physician-sponsored program.

The client is informed through choice counseling that is provided by the State. We have worked closely with the consumer and provider groups and have an ongoing monitoring committee to assure that the information presented is complete, accurate, unbiased, and clear. As a result, we believe recipients participating in the project, will be better informed consumers regarding the health care system.

The State engaged in extensive consultation with the recipient and the provider community during the design and implementation of this project. We invested thousands of staff hours over a year's time in meeting with every group and individual interested in the project. holding public hearings, legislative briefings, and so forth. As a result, our project enjoys widespread support in the community.

Access to the health care system will be guaranteed for the first time under this project. Once the provider of choice is selected by the client, access to the health care system is guaranteed. Recipients will no longer have to struggle for access to the system each time a medical need arises, and continuity of care will become a reality.

Protections for the clients to avoid unscrupulous or incapable health plans have been assured, we believe. In addition to federally qualified HMO's, the State has developed contracts for prepaid health care with mainstream medical providers who have served medicaid clients and the general community for many years; who are financially viable; and who enjoy good standing in the health care community.

Quality assurance mechanisms are extensive in this project. Prepaid health care will undergo far more rigorous scrutiny than the historical fee for services program.

Patients' satisfaction is built into the project. Satisfaction surveys will be administered and evaluated throughout the project in order to improve the project. Disenrollment procedures are specified to protect the rights of the client and to insure reasonable movement within the system. And last, savings are guaranteed to the State since prepaid reimbursement is set at 95 percent of fee for service.

I would also like to voice the concerns Missouri has about existing restrictions in the 1903 language and the TEFRA prohibition on waivers of these restrictions.

Specifically, the prohibition of more than 75 percent of PHP enrollees being medicare-medicaid eligibles is unnecessarily restrictive because Missouri, like many States, does not have a well-developed HMO system, so we had to develop prepaid health plans specifically for the medicaid client. As a result of the current language, we would lose four of our prepaid health plans because they are 100 percent medicaid. In addition, the monthly disenrollment on demand provisison, we believe, while well intended, is undesirable for two reasons. First and most importantly, it effectively negates the case manager concept inherent in the prepaid program. Some restrictions—the case management concept specifically—can result in improved health care delivery. There are other ways to

protect the rights of the individual client in this process without underminding the basic premise of the prepaid concept.

The prohibition on contracting with the prepaid health plan that is not a State or federally certified HMO is counterproductive. The Missouri project would lose two of its six prepaid health plans under this provision. These provisions, therefore, inhibit the development of prepaid health care.

We believe the Missouri project has actually resulted in greater freedom of choice for the medicaid client.

New providers—the federally qualified HMO's—have been enrolled for the first time. Clients are fully informed about a wide range of choices and given more information than ever before in making a decision about where to get health care. The promise of guaranteed access is perhaps the greatest freedom of all. Current provisions in 1903 with the TEFRA restrictions on waivers are not appropriate vehicles to protect the medicaid client. States have no less concern than Congress about safeguarding clients from the poor provision of health care, and States perhaps have even a keener and more immediate interest in the success of new approaches for the delivery of health services to medicaid clients. States can and will act responsibly in using greater flexibility provided through the Federal structure, and we urge you make certain such flexibility is guaranteed.

Thank you.

Senator DURENBERGER. Thank you very much. Mr. Allen.

[The prepared statement of Sharon Marcum follows:]

Statement Presented by Sharon Marcum
Deputy Director, Missouri Department of Social Services
Senate Finance Committee Subcommittee on Health
Friday, March 30, 1984.

Mr. Chairman and Members of the Committee:

I would like to provide this subcommittee with information about the Missouri prepaid health demonstration project and to let you know why the State of Missouri strongly supports greater flexibility for states in designing and implementing alternative health care financing and delivery systems for Medicaid. We are concerned about the current restrictions contained in §1903(m) regarding prepaid arrangements. Section 1903(m) restrictions -- the limit on the percentage of Medicaid recipients allowed in prepaid health plans, the monthly disenrollment of recipients from preaid plans, and the prohibition on contracting with any entity other than a certified HMO or PHS grantee -- seriously threaten our ability in Missouri to continue projects underway and, in our opinion, will retard development of much needed reforms in Medicaid.

In Missouri, both the State and Kansas City (Jackson County) provider community have invested significant time, effort and resources in establishing a prepaid health plan for Medicaid recipients. Based on the success of the Kansas City project to date, we plan to expand to St. Louis. The current provisions of

§1903(m) threaten the long-term stability of Missouri's approach to reforming Medicaid.

Problems with Traditional Medicaid Program

The traditional Medicaid program has proven costly and has not necessarily provided good health care.

In 1981, Missouri was faced with out-of-control Medicaid costs, with spending increasing in that year alone by 37% or $120 million. Equally troubling, an examination of key program indicators revealed that not only were the costs unaffordable to the state of Missouri but that health care was inadequate. Specifically, ongoing primary and preventive care was lacking, with the majority of health care services being provided in expensive institutional settings. The use of hospital days by the Medicaid population was over 1600 days per 1,000 eligibles, a rate that exceeded national Medicaid hospital use by 35% and privately insured individuals by over 100%.

Use of expensive emergency rooms for routine primary care in the Missouri Medicaid was commonplace. Medicaid patients did not often enjoy a stable, ongoing relationship with one primary care physician. Traditional Medicaid presents a problem for many clients: finding physician willing to accept them as a Medicaid patient. In working with client groups to address the high rate

at which emergency rooms were used for routine care, we found this was all too often the most accessible provider available to recipients whenever they needed care and one they could be assured would accept their Medicaid card.

Missouri Prepaid Program

Part of the solution to the multiple problems inherent in the traditional Medicaid program is prepaid health care. Missouri was one of five states to be awarded HCFA demonstration grants and waivers in June, 1982, to develop alternative models in Medicaid. Under the authority of Section 1115(a)(1) six waivers of the provisions of the Social Security Act were granted to Missouri in order to carry out the project. These waivers included one that provided the State the ability to implement the program on less than a statewide basis; three waivers that allowed the State to provide incentives to recipients to enroll in alternative health plans; and two that would allowed the State to restrict freedom of choice of providers.

I am pleased, today, to report on the progress of that project made possible by these waivers. The approach Missouri has taken in designing its Prepaid Health project is a good example of responsible state use of federal flexibility. Thirty thousand AFDC recipients in Jackson County will choose among six prepaid health plans (PHP) or a physician sponsor program. Once

a choice has been made, the recipient will be required to receive all care or have any necessary referrals made by the provider of choice. Bona fide emergency care is, of course, always covered, regardless of where obtained. Prepaid health plans will be paid a fixed, capitation premium each month for eligible enrollees and will be at risk if the cost of care exceeds the premium. Physician sponsors will serve as gatekeepers, receiving a monthly case management fee in addition to the usual fee for service reimbursement. To date, over 7,500 clients have made the choice with 77% choosing a PHP and 23% choosing a physician sponsor. The key elements of the project include:

. A wide range of choices for the AFDC recipient, with prepaid health plans being offered by two federally qualified HMO's, two neighborhood health centers, one public hospital and one teaching hospital. In addition, the individual physician has been retained as a choice via a physician sponsor program.

. Choice counseling. The State will present the full range of choices to the recipient, using video tapes, brochures, group presentations and individual sessions. We have worked closely with client groups as well as the providers to assure a complete, accurate, clear and unbiased presentation of information. As a result, we believe the recipients who participate in this project

will be better informed consumers regarding the health care system in general, the options available in the local health care delivery system, and good health care consumer practices. The emphasis throughout is on the importance of a medical gatekeeper, guaranteed access, and improved care patterns through earlier intervention.

. Extensive consultation with the recipient and provider community during the design and implementation of the project. We invested thousands of staff hours over a year's time in meeting with every interested provider or recipient group or individual to discuss the project. We formed both recipient and provider advisory committees and listened to their concerns and ideas in implementation of the project. Public hearings were held and legislative briefings were provided. As a result, the Missouri prepaid project enjoys widespread support and became operational in November of 1983 with no resistance or litigation impeding its implementation. The physician associations have provided advisory and peer review committee members, the hospital association has formally endorsed the project and the Kansas City welfare rights organization has actively worked with the State throughout the project's development.

. Guaranteed access to the health care system. Once the provider of choice is selected by the AFDC recipient, access to the appropriate health care will be assured. Both PHP's and physician sponsors are required to be available to enrollees for consultation 24 hours a day, 7 days a week. Recipients will no longer have to struggle for access to the system each time a medical need arises. The case manager concept will provide continuity of care for the Medicaid recipients.

. Protections for clients to avoid unscrupulous or incapable health plans. Legitimate and viable PHP's have been developed in Missouri. In addition to federally qualified HMO's, PHP contracts have been developed and signed with existing fee-for-service providers who have served the general community and Medicaid recipients for many years, who are financially viable and who have good standing in the health care community. Creative risk management provisions were developed so that PHP's are at risk for factors in health care costs within their ability to manage and control, but not for those elements beyond their control. Expert actuarial analysis was used in setting rates adequate to provide good care, but that should result in at least a 5% savings to the State.

Quarterly cost reporting as well as regular financial audits are required.

. Quality of care assurance mechanisms are extensive. Prepaid health care arrangements will undergo far more rigorous scrutiny than the historical fee-for-service program. Each plan is required to have internal quality of care programs that will be reviewed by the State. Every encounter by a Medicaid enrollee will be reported to the State, including diagnosis and procedure. This data will be profiled and used by the State in conducting quality of care review. The State will conduct on-site medical audits at each plan regularly. A locally based medical director will oversee the project and a full peer review system has been established.

. Patient satisfaction is built into the project. Baseline data has been gathered regarding recipient satisfaction with the existing fee-for-service system and will be collected for the new system of health care provided under the project. These satisfaction surveys will be administered and evaluated regularly and used to improve the project.

. Disenrollment procedures are specified to protect the rights of the recipients and insure reasonable movement within the system. Within the first 30 days after making the initial selection, a recipient can exercise "buyer's remorse" and change providers without cause. After the initial six months of enrollment, a client can elect to change providers and will then be enrolled for at least a six-month period. A full grievance process is provided so that recipients can disenroll from a provider with cause anytime throughout the project.

Smooth implementation has been enjoyed by the Missouri project. We have taken the time necessary to work out problems along the way, resisting premature implementation of any phase of the project. We have tested and checked out all systems support for the project before implementation, thereby insuring accuracy in the enrollment and reimbursement for prepaid health. And as mentioned earlier, a continual dialogue has been maintained with the provider and recipient community.

Section 1903(m) Problems

The adverse impact the existing §1903(m) provisions would have on continuing the Missouri project beyond its demonstration status are a major concern to Missouri. Section 1903(m) language is step

back for needed reform of the Medicaid program. Our principle concern about §1903(m) in Missouri are:

. Enrollment Restrictions. Prohibition of more than 75% of any PHP enrollees being Medicaid/Medicare eligibles is unnecessarily restrictive. Missouri, like many other states, lacks a well developed HMO system. Missouri obtained specific statutory authority for developing such PHPs. Because these PHPs act as a prepaid plan only to Medicaid recipients, they are exempt from Missouri insurance laws and regulations. As a result, with the exception of the two federally qualified HMO's, the prepaid enrollment in the four additional PHP's is 100% Medicaid. While the two hospital plans as well as the two neighborhood health care plans would clearly meet such a 75/25 ratio for their entire facility caseload, they are only offering prepaid health financing for Medicaid recipients and, hence, would be ineligible to continue under the §1903(m) provision.

. Monthly disenrollment on demand. Such a requirement, while well-intended, is undesirable for two major reasons. First and most importantly, monthly disenrollment effectively negates the case management concept inherent in the prepaid concept. Medicaid programs must have the ability to design new

incentives, both for providers and recipients. Utilization and price controls are reasonable components of a health care system. Some restriction -- the case management concept for medical care services -- can result in improved quality health care delivery. Disenrollment on demand continues the historical problem of poorly informed consumers making choices with little price sensitivity in health care decisions. This feature could also results in administrative chaos in actual operation. There are ways to protect the rights of the individual client in this process without undermining a basic premise of the prepaid concept.

. Limiting Potential Prepaid Providers. Prohibition on contracting with a PHP that is not either a state certified HMO or an entity receiving at least $100,000 annually in PHS grants since 1976 is counterproductive. The Missouri project would lose two out of its six PHPs under this provision. Section 1903(m), therefore, would inhibit the development of new prepaid plans. Neither the public nor the teaching hospital would meet either of these requirements. Equally as important, many of the institutions in St. Louis who have expressed an interest in developing a Medicaid PHP would not qualify. Other safeguards need to be considered that would

provide assurance of legitimate prepaid arrangements without such prescriptive and unduly restrictive language in the federal statute.

The entire nation has developed a new consciousness and set of expectations for the health care system. Private business is struggling to begin purchasing health care with the same business approach used to purchase other commodities. States have finally been able to gain control of Medicaid programs long considered to be uncontrollable. The federal government is at last changing some of the more perverse incentives built into the alarmingly out of balance Medicare program. It is unfortunate of Congress to now erect barriers for states in developing more rational approaches to the financing and delivery of Medicaid services. We recognize and share the concerns Congress has in insuring that prepaid arrangements provide quality care, that providers are legitimate, and that widespread abuse of such approaches do not develop, but the §1903(m) language is not the answer.

Perhaps the most important point to make is that expanded use of prepaid health arrangements by state Medicaid programs often represents an improvement in how services are financed and how care is delivered -- not a creation of a new alternative health care system. Safeguards which might be appropriate for a new industry are not appropriate when dealing with established providers with a long history of service to Medicaid recipients.

As a practical matter, states must consider existing providers and patterns of service delivery when making changes to the system. The Missouri project incorporates existing major Medicaid providers into the prepaid project, thereby insuring continuity of care for clients who had chosen these providers in the traditional system with no restrictions on freedom of choice.

Secondly, informed freedom of choice is most relevant at the outset of the patient/provider relationship. Once this mutual commitment has been made, dissolution of the partnership should be undertaken by either party only when based on cause.

And lastly, we believe the Missouri project has actually resulted in greater freedom of choice for the Medicaid clients. New providers -- the federally qualified HMO's -- have been enrolled for the first time. Clients are fully informed about a wide range of choices and given more information than ever before in making a decision about where to get health care. The promise of guaranteed access is perhaps the greatest freedom of all.

However, the §1903(m) provisions as they currently exist are not the appropriate vehicles to protect Medicaid clients. States have no less concern than Congress about safeguarding clients from the poor provision of health care, and states have perhaps even a keener and more immediate interest in the success of new approaches for the delivery of health services to Medicaid

clients. States can and will act responsibly in using greater flexibility provided through the federal structure and we urge you to make certain such flexibility is guaranteed. Together, we can redesign the Medicaid program. Our common goal must be not only an improved health service delivery system but a more responsible financing system that uses scarce resources in the best way possible.

35-234 O—84——4

STATEMENT OF PAUL ALLEN, DIRECTOR, MEDICAID SERVICES ADMINISTRATION, MICHIGAN DEPARTMENT OF SOCIAL SERVICES, LANSING, MI

Mr. ALLEN. Senator, this is about the third time I have appeared before your committee on some of these issues with a sort of status report. And I have got some good news, and I have got some bad news. The good news is that section 2175 waivers do work. We have had several in Michigan for over a year, and the one that has worked the best is the one that has allowed us to go into a primary care network, much as Jack Meyer was talking about, to the extent that 16 percent today of our medicaid population is in some form of primary care network, either in a health maintenance organization or in a primary physician-sponsored plan waiver which we received last year. That 16 percent represents 130,000 people in the State of Michigan. Medicaid individuals are in primary care network type approach, most of them in an HMO.

We expect by next year to have 40 percent of the medicaid population in a primary care network—either an HMO or a primary physician sponsored plan. And so, the waiver process helped us to move forward in this area by waiving the freedom of choice issue. We do provide freedom of choice through physicians and HMO's, but it is mandatory in the major catchment area, which is Detroit, Wayne County.

They may choose one or the other, and it is working and it had some political problems getting started because we are, for the first time, restricting the freedom of choice.

It is providing mainstream access to the clients concerned. The initial returns say it is economical. It is cost effective. It is giving us some of the same benefits we got in the HMO's, and that is minimizing the hospital care, both inpatient and outpatient, as a lot of our clients didn't even have a doctor until we got into this form of operation. So, on balance, it looks real good, and we will know more in about a year. We have an evaluation project sponsored by HHS that is allowing us to move forward and evaluate this thing objectively.

The bad news is that in support of what Sharon said, Michigan is having a problem with 1903(m) in terms of the restriction of 75/25 match for public versus private enrollees. We have no public HMO's in the State of Michigan. All we have is private, and two of them have exceeded the 75 percent threshold because their catchment area is in the medicaid population centers of the State, and they have great difficulty making the 75/25 split, to the extent that if we follow the letter of law, I am going to have to cancel a contract tomorrow because my waiver expires on the 75/25 match under 1903(m), and I can't, in good conscience, cancel that contract. It is saving the State and Federal Government over $2 million a year just for one HMO. We have over 30,000 enrollees in that HMO. They are getting quality care. It is a licensed State and Federal qualified HMO, and yet we are being forced by the law to cancel the contract, and won't do it. So, it may cost the State money, but we have got to change that law. If you are a public HMO, you can get a waiver. But if you are a private HMO, you can't, and to me it is an anachronism that we should be allowed to

have this continue. In closing, I think that the long-term approach for all medicaid enrollment and care in the future is going to have to be a case management approach.

We are experimenting with 2,000 or 3,000 in Michigan. We are experimenting with hundreds of thousands, and our initial output says that, at a minimum, it is going to be 5 percent cheaper and probably it is going to be 10 or 15 percent, and at a maximum, we are already seeing that it is forcing hospitals to close outpatient departments and emergency rooms because there is a shortage of patients. And this is a health care turnaround over the past 10 years. Ten years ago, there was a shortage of doctors and health care resources. Today, there is a shortage of patients.

And the 2175 waiver in all it holds for promise has exacerbated the competition with these limited patients. And we think it is the only way to fly for the future.

Senator DURENBERGER. OK. Thank you very much.

Ms. Morrison.

[The prepared statement of Paul M. Allen follows:]

Testimony of Paul M. Allen, Director, Medical Services Administration, of the Michigan Department of Social Services before the Senate Finance Committee on March 30, 1984.

SUBJECT: Section 2175 Waivers of Freedom of Choice under the Omnibus Budget Reconciliation Act (OBRA) of 1981 and the impact of changes brought about by TEFRA of 1982 as it relates to the prohibition of Medicaid contracting with a private HMO that has more than 75% of their enrollees consisting of Medicaid and Medicare beneficiaries.

The State of Michigan requested a waiver from the Department of Health and Human Services of Section 2175 of OBRA in November 1981. The portions of the Social Security Act specifically waiver were sections 1902(a)(1) and (23). The waivers were needed to implement a physician case management arrangement known as the Physician Primary Sponsor Plan. This Plan has enrolled Medicaid beneficiaries with primary care physicians in Wayne County, Michigan, since 1982. The major objectives of this case management system are four in number:

1. To increase physician participation in the Medicaid Program,
2. To provide recipients better access to the health care system,
3. Better management of the use of medical services, and
4. To control costs in the Medicaid Program (particularly hospital services) while paying equitable fees to physicians.

One of the major features of the Physician Primary Sponsor Plan was a limitation of the Medicaid recipients' freedom to choose their health care provider from among physicians and HMOs participating in the Plan. This restriction on freedom of choice was the major reason for requesting a waiver authorization under the provisions of OBRA of 1981.

Subsequent to approval of our waiver request, the Michigan Medicaid Program working with the beneficiary and physician communities commenced the Physician Primary Sponsor Plan in Wayne County. Approximately 1,100 primary care physicians in the county signed contracts with the Medicaid Agency. This is about 55% of practicing MDs and DOs classified as primary care physicians in Wayne County.

The Physician Primary Sponsor Plan in the past 20 months has enrolled 38,000 Medicaid recipients, primarily in the Detroit area of Wayne County with appropriate primary care physicians. In addition, as a result of the competition generated by the case management approach, there has been an exponential increase in enrollments by Medicaid recipients in health maintenance organizations (HMOs) in Wayne County. Consequently, there are approximately 80,000 Wayne County Medicaid recipients enrolled in HMOs as of this month. In addition, in 1982 we launched another HMO-like option under the 1981 and 1982 "flexibility" sections of Title XIX of the Social Security Act. This option called the Capitated Ambulatory Plan now has 2,000 enrollees in Wayne County. In sum, there are approximately 120,000 of the targeted population of 320,000 Medicaid eligibles in Wayne County now enrolled in some form of case management arrangement. We have accelerated our enrollment activity and expect that within the next 18 months that all 320,000 Medicaid recipients in Wayne County will be in some form of a case management arrangement. As soon as we have digested this elephant-sized project, we will be moving into other counties in Michigan.

Though it is a bit early to make an accurate assessment of the impact of this case management activity, initial indications are that most of its objectives

will be fulfilled. A small sample taken from the 38,000 enrollees mentioned earlier indicates that this small group and the physicians serving them have been effective in providing access to mainstream health care while reducing almost every facet of health care costs as compared to their counterparts who were not enrolled in the system. Further the sample group's health care expenses are much less than they were before they entered the system. With respect to HMO enrollees, we have had contractual arrangements with HMOs in Wayne County since 1972 and we know that this form of health care delivery is both cost effective and provides accessible care of high quality. As an aside, our average savings with Medicaid HMO enrollees is 10 cents on the dollar as compared to fee-for-service. This will amount to 6 million dollars in savings to Medicaid in Michigan this year for our growing HMO enrollments.

The Physician Primary Sponsor Plan because of its significant impact on the health care delivery system is being intensely monitored by all interests involved through a steering committee which I chair. Those involved include client advocacy groups, the osteopathic and allopathic physicians throughout the state, the Legislature, the hospital industry and the executive branch of government and other interested parties. The Department of Health and Human Services has also financed an evaluation project through which we can make a sophisticated and hopefully objective evaluation of the impact of the case management approach from every perspective. However, the HHS sponsored evaluation project is of long duration and will probably not provide meaningful information for at least six more months.

My report today is that, based on early returns, the case management approach

and related expansion of HMO-like capitation arrangements holds great promise for containing costs while improving access of Medicaid clients to the health care system. I expect that in both the short term and long run, it will divert Medicaid beneficiaries away from both inpatient and outpatient hospital care. Over the years, many of our beneficiaries have become dependent on these expensive forms of health care delivery because of lack of access to other forms of ambulatory care.

The waiver authority granted by OBRA has been most valuable to Michigan in our efforts to implement innovative and cost effective health care delivery systems We intend to use this authority wisely and judiciously to improve services statewide while husbanding our scarce resources.

With respect to the second part of my message, I have a different story. Michigan is being severely handicapped in our efforts to maximize HMO enrollments with private organizations because of the fact that in two of our Detroit-based HMOs more than 75% of their enrolled population are Medicaid or Medicare beneficiaries. There is a limit in Section 1903(m) of the Social Security Act which was placed there by TEFRA and its background discussion. This limitation on Medicaid/Medicare enrollees is apparently not subject to waiver except for "Public HMOs". Why this distinction, we do not know. We do know that we have no public HMOs in Michigan. Two of the seven HMOs we do have contracts with in South East Michigan serve in excess of 50,000 Medicaid/Medicare enrollees and they serve them quite well. Because their population mix exceeds the 75-25% formula, I am being forced imminently to consider cancellation of these vital cost effective contracts. These HMOs are providing quality care at great savings under state and federal licensure/certification standards to an underserved population. The law and Social Security Act need to be changed now to resolve this anachronism. We need your help to restore some sense to our efforts to expand proven health care delivery systems such as privately owned and financed HMOs that are willing and able to serve the Medicaid population.

STATEMENT OF KATHRYN MORRISON, ADMINISTRATOR, DIVISION OF HEALTH, WISCONSIN DEPARTMENT OF HEALTH AND SOCIAL SERVICES, MADISON, WI

Ms. MORRISON. Thank you, Mr. Chairman. For the last couple of years it has been Wisconsin policy to encourage HMO's in all sectors. We have done this in a number of ways. First we passed a law that requires each firm having over 250 employees within the State to make an HMO or PPO option available to their employees, if one exists within their geographical area. Second, we have gone through a process of tring to encourage medicaid recipients to enroll in HMO's—I will speak more about that.

Third, in the last year, we have encouraged State employees to join HMO's. In the last year, 60 percent of all the State employees who could join HMO's did so.

These employees are asked to participate in the HMO for a period of 12 months. They then have an opportunity to disenroll.

Why are we so involved in encouraging HMO's? For two reasons, one of which is we believe in the importance of creating a system which emphasizes prevention and primary care. We believe a capitated system does that. The second reason is that we are obviously concerned about overall costs. We are concerned about the kinds of actions that we in the State of Wisconsin and other States have taken in the last couple of years with regard to medicaid. It is true in Wisconsin that, while medicaid was going up at 17 to 18 percent in the last part of the 1970's, it has, except for the last year, been going up at a rate of 3 or 4 percent in Wisconsin. Why is that? That is because we made people no longer eligible for medicaid. We just lopped some people right off the rolls. We also cut back severely on certain benefits. We do not wish to do that any more. We would prefer to have another kind of approach. That is the reason that we are encouraging HMO's as an alternative approach to putting some constraint on costs.

We are finding in Wisconsin that the HMO's that are interested in bidding for MA patients are the same ones that already have State employees.

There are 15 HMO's involved—11 of those HMO's are HMO's which have a significant number of State employees already in it. Four others will be new HMO's although they are providers which have been traditional MA providers.

For instance, the several community health centers in Milwaukee have gotten together and created an HMO. These new HMO's also include one of the smaller religious hospitals located in the inner core of Milwaukee—Milwaukee Children's Hospital, which has about 40 percent of its clientele medicaid—and Milwaukee County institutions which also have a high share of medicaid patients. So, what we find is that the HMO's interested in the MA in State of Wisconsin fall into two categories. One is the group of HMO's just interested in serving patients including Medicaid. Their first set of clients are people from businesses and state employees. The second group are those which have been traditional fee-for-service MA providers.

We believe that this is going to be a very beneficial kind of system because we will have an HMO system which is built around

the needs of workers—people who are reasonably sophisticated in ensuring that they get good care. We believe that is important for quality insurance. We are, of course, not only counting on that to ensure quality. We are asking that HMO's have both an informal and a formal grievance procedure. We have found through experience in the two HMO's that exist for Medicaid right now that, in fact, the informal system tends to solve most problems quickly and efficiently. The State will audit these systems periodically. We will also be contracting with the University of Wisconsin Madison to take a serious look over the next couple of years at quality and patient satisfaction in all the HMO's providing care for medicaid.

We have found thus far that we are saving about 5 percent. We believe this will eventually rise to 10 percent. I think that in the future this means savings in the range of $15 to $20 million a year on the Wisconsin system.

We believe that to continue to make it work we are going to need the ability to waive some of the freedom of choice conditions. Specifically we believe that it will be necessary to have MA enrollers commit to 6 months or more. State employees now commit to 12 months. We also believe that when we have a variety of HMO's to offer, the individual on medicaid should be required to choose from among that group. Thank you.

Senator DURENBERGER. Thank you very much.

Ms. Wasek.

[The prepared statement of the Wisconsin Department of Health and Social Services follows:]

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STATEMENT

of the

WISCONSIN DEPARTMENT OF HEALTH AND SOCIAL SERVICES

on

WISCONSIN'S HEALTH MAINTENANCE ORGANIZATION PREFERRED ENROLLMENT INITIATIVE

before the

SENATE SUBCOMMITTEE ON HEALTH

of the

SENATE COMMITTEE ON FINANCE

March 30, 1984

WISCONSIN's

HEALTH MAINTENANCE ORGANIZATION PREFERRED ENROLLMENT INITIATIVE

Thank you, Mr. Chairman, for allowing me to present this testimony on the waiver of Medical Assistance freedom-of-choice in Wisconsin. I am Kathryn Morrison, Administrator of Wisconsin's Division of Health.

OVERVIEW AND BACKGROUND

In Wisconsin, it is state government policy to encourage HMO formation and growth in order to help control health care costs and to provide high quality care. Major State legislation was passed in 1983 to facilitate HMO operations. The State Health Plan calls for major HMO formation and growth.

Wisconsin State government also is using its buying power to encourage HMOs. In November, 1983 State employees went through an "open enrollment period" in which they were given a choice of an HMO or the standard fee-for-service plan. The State pays 107 percent of the lowest cost plan for State employe health insurance, and the employe pays the difference between that amount and the premium of the specific health care plan. There was a strong incentive to join an HMO because their premiums were lower. In Dane County, over 60 percent of State employees had enrolled in HMOs as of January 1, 1984.

State government is also expanding enrollment of MA recipients into HMOs. The waiver of the federal MA freedom-of-choice law permits Wisconsin to require enrollment into HMOs. If there is only one HMO/MA contract in an area (as is the case now with contracts in Marshfield and Madison), the MA

recipient must be given the option of disenrolling. If there are two or more HMO/MA contracts, the MA recipient can be required to choose one of the HMOs. Currently the State has implemented only the first type of restriction for the Greater Marshfield Community Health Plan in Marshfield, and the Group Health Cooperative in Madison.

The freedom-of-choice waiver accomplishes the following important objectives:

1) Increases enrollment of MA recipients in HMOs. HMOs provide comprehensive health care at a cost-savings, focus on preventive care, and ensure continuity of care.

2) Treats MA recipients like State employes by increasing enrollment in HMOs.

3) Controls health care costs without reducing services.

THE NECESSITY OF HAVING AN ENROLLMENT COMMITMENT PERIOD LONGER THAN THIRTY DAYS

In 1981, federal law was changed to require that HMOs permit MA recipients to disenroll as of the first of the month after a 30 day notice period has passed. In 1982, the Federal Government eliminated the authority of the Department of Health and Human Services to waive the thirty day disenrollment option for programs of primary care case management. Lack of an enrollment commitment period is a major barrier to the full success of Wisconsin's HMO enrollment plans. HMOs achieve their typical high level of success by having

an enrolled population for an extended period of time and being able to manage health care. Without the enrollment commitment period:

--The MA recipients will have inadequate time to experience HMO care and make an informed choice about enrollment.

--The HMOs will have insufficient time to demonstrate effective provision of health care delivery, education, and health maintenance services.

--The HMOs will be unable to make sound financial plans.

--The State MA Program will have higher than necessary costs for processing enrollment-disenrollment.

--The MA recipients will not be treated similarly to other enrollment groups which have enrollment commitment periods.

The Preferred Enrollment Initiative can be implemented without a six-month enrollment commitment, but there is no question that the six-month enrollment would enhance every aspect of the program, including quality of care, continuity of care, effective provision of health maintenance services, and control of enrollment-disenrollment costs. State employes have a twelve-month enrollment commitment, compared to the six-month enrollment contemplated for MA recipients.

IMPLEMENTATION OF WISCONSIN'S HMO PREFERRED ENROLLMENT INITIATIVE

In the rural Marshfield area, enrollment of MA recipients into the Greater Marshfield Community Health Plan went from 600 to 4,300 in 1983 because of this Initiative. When informed of HMO enrollment under the Preferred

Enrollment Initiative, MA recipients can choose not to be enrolled, but only about 10 percent do so.

Because Marshfield now has about 90 percent of the MA recipients enrolled, it is in a good position to plan for and manage the health care of the MA population. With less uncertainty about the enrollment level and with greater ability to plan for the MA population, we expect increased cost-effective delivery of care.

In Madison, enrollment into the Group Health Cooperative (GHC) of South Central Wisconsin increased from 100 to 1,200 in 1983. When informed of the Preferred Enrollment Initiative, about 60 percent decided not to be enrolled. The 40 percent GHC enrollment is considered very high for the urban Madison setting.

In 1984, the Initiative will be greatly expanded in Dane County and Milwaukee County. A total of five HMOs in Dane County and fourteen in Milwaukee have submitted proposals to serve the MA population. The Department is now evaluating their proposals and plans to contract in May. Most of the HMOs that have submitted proposals are already operational and serving large numbers of private enrollees. The newer HMOs are traditional providers of care to the MA population on a fee-for-service basis. Wisconsin requires that all HMOs be certified and regulated by the Office of the Commissioner of Insurance.

There are 10,000 MA-Aid to Families with Dependent Children eligibles in Dane County and 110,000 in Milwaukee County. The expansion of the Preferred

Enrollment Initiative will enroll about 6,000 of the Dane eligibles and 30,000 of the Milwaukee eligibles in HMOs in the first year. As HMOs grow, the Initiative will expand to other aid categories and areas of Wisconsin.

Milwaukee has about one-fourth of the population of Wisconsin, and about thirty percent of the MA population. Thus, the HMO Initiative expansion in Milwaukee can have a dramatic impact on the enrollment of MA recipients into HMOs.

IMPROVED RECIPIENT ACCESS TO CARE/QUALITY OF CARE

Wisconsin requires HMOs to provide 24 hour-a-day, 7 day-a-week access to quality care. HMOs must pay for emergency care provided by non-HMO providers. HMOs must demonstrate to the satisfaction of the Department of Health and Social Services that they have the space, capacity, and ability to provide quality care to MA recipients, before contracts are signed.

Wisconsin requires that HMOs must have a formal grievance procedure, an informal grievance procedure, and that MA enrollees dissatisfied with the outcome must be able to appeal to the Department for a final and binding determination. The combination of these processes will give an MA client more redress than under the fee-for-service program.

The Department will conduct annual medical audits to review the HMO quality assurance plans, implementation, and follow-up. The Department will also operate its own quality assurance system. To summarize and identify any problems, the Department will use a computerized information system.

The Department will conduct an extensive research and evaluation effort with the University of Wisconsin Center for Health Policy and Program Evaluation. Quality of care, utilization patterns, and cost-effectiveness will be examined in the evaluation.

The Department fully expects this Initiative to result in an improvement in access to quality care. We already see evidence of this in the planning efforts by HMOs for the Initiative. HMOs recognize the need to attract and satisfy the MA recipients. For example, the Greater Marshfield Plan and Group Health Cooperative have employes designated to assist MA recipients with enrollment and service questions. We expect to see the MA eligibles become one of the more sought after consumers of health care.

HMO enrollment provides many advantages for MA recipients:

--no MA co-payments;

--no MA prior authorization;

--no MA required second opinions;

--HMO emphasis on prevention and health maintenance;

--central location of medical records;

--coordinated care;

--guaranteed coverage when MA eligibility ends;

--guaranteed access;

--state-monitored grievance systems;

--HMO emphasis on satisfaction to retain membership;

--replacement of "welfare" identity with "HMO member" identity.

All these advantages will ensure and increase MA recipients access to quality, mainstream medical care.

HMO SUCCESS IN CONTROLLING UTILIZATION AND EXPENDITURES

The Greater Marshfield Plan and the Group Health Cooperative have already achieved remarkable success in controlling costs and utilization. The hospital utilization at Marshfield has decreased from over 900 days per thousand MA enrollees in 1981 to about 500 in 1983. Group Health Cooperative has succeeded in reducing hospital utilization from over 1,000 days per thousand to about 475 days in 1983. This success illustrates what can be expected in the large scale implementation in Dane and Milwaukee Counties in 1984. These decreases in hospital utilization bring MA utilization patterns more in line with the rest of the population.

State reimbursement of the Greater Marshfield Plan and Group Health Cooperative has actually decreased over the last two years.

Overall savings to Wisconsin's MA program from HMO enrollment will be about $100,000 in state fiscal year 1984 and about $1 million in fiscal year 1985. Savings in fiscal year 1986 will be over $2 million. As the Initiative expands to include additional recipients, other aid categories, and other geographical areas, savings will increase further.

35-234 O—84——5

STATEMENT OF SHARON A. WASEK, DIRECTOR, DIVISION OF HEALTH CARE FINANCING, UTAH DEPARTMENT OF HEALTH, SALT LAKE CITY, UT

Ms. WASEK. Thank you, Mr. Chairman. In the interest of time, I will focus my comments on some of the more salient aspects of Utah's program because I think, in many respects, some of the comments you have heard from my colleagues are very similar to our experience in Utah, and my written testimony, I think, gave you a pretty exhaustive analysis of how our program was implemented.

Basically, in Utah we implemented our case management—our freedom of choice waiver—on a phased-in implementation, with the full support of the Utah State Medical Association and the consumer advocates. This, we felt, was very essential and has proved to be one of the most beneficial aspects of our program. We chose to put health care representatives in the field to interact with the client on a face-to-face basis. Again, this was a very key aspect of the approach we took. We developed a list of physicians who were willing to take new medicaid clients. We obtained the physician support up front and their official endorsement, which avoided the need for clients to establish their own mechanism for finding physician care. The face-to-face contact also provided the client with an improved level of medical care understanding.

Futhermore, this approval has resulted in improved third party liability information collection and third party collections. We have increased the number of preventive health care screenings for children, all because of this one-to-one relationship between the State health coordinator and the medicaid client. We have shown in the 1 year that we have accrued a savings of $4 for every $1 spent on administrative costs, and we have increased the physician participation in medicaid by 15 percent. The savings are a result of the reduction in the number of services as opposed to reduction in fees. Because of the support of the Utah State Medical Association, we have not had to pay physicians a case management fee, as some of the other States have.

You may be interested in some of the other ways in which Utah has used the 2175 waiver authority. We have applied for and received approval to selectively contract for hospital services, similar to the California experiment. With the cooperation of the Utah Hospital Association, we chose to implement on the DRG reimbursement instead. We view it as an interim method of payment to collect more data in terms of case mix. This was implemented State-wide on July 1, 1983. Our long-range objective beginning next year will be to do selective contracting by DRG.

We also are evaluating the feasibility of selective contracting for long-term care services. The reason that we are considering this is that we are currently on a prospective flat-rate reimbursement system for long-term care. We do have a surplus of beds in the State of Utah, brought about by an aggressive preassessment and home community-based care programs, and with the experience of a flat-rate system, it has demonstrated that this approach in reimbursement does not provide an incentive for quality of care, the

payment is neither reflective of the level of services provided, or the level of services needed by the client.

Under this system some providers report considerable profits while others report financial loses.

We want to move into a more competitive marketplace, and the surplus of beds should allow us to do this. We have also successfully contracted for selective medical equipment and show considerable savings. Thank you, Senator.

Senator DURENBERGER. Thank you very much.

[The prepared statement of Sharon A. Wasek follows:]

Scott M. Matheson
Governor

STATE OF UTAH
DEPARTMENT OF HEALTH
DIVISION OF HEALTH CARE FINANCING
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State Health Laboratories

HET-092-84

March 26, 1984

Mr. Roderick A. DeArment
Chief Counsel
Committee on Finance
United States Senate
Washington, DC 20510

Dear Mr. DeArment:

As the Medicaid Director for the State of Utah I am looking forward to testifying before the Committee on Finance concerning Utah's "Freedom of Choice" program as established by our 1982 waiver. Enclosed are 100 information packets describing our method of managing Medicaid's Case Management Program. The first page of the packet is a summary, and the remainder is to provide details of the program.

Thank you for this opportunity to present our ideas. We feel that Utah is making great progress in providing better quality care at controlled costs for all Medicaid recipients.

Sincerely,

Sharon A. Wasek

Sharon A. Wasek, Director
Division of Health Care Financing
P.O. Box 2500
Salt Lake City, Utah 84110

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Enclosure

The Utah "Freedom of Choice" Waiver

The high cost of medical care, with no controls for the recipient and complete freedom of choice, creates very expensive health care. Many Medicaid clients use multiple providers for their care; also, clients were unable or unwilling to find a doctor who would take complete charge of their care. Therefore, we saw considerable use of emergency services and excessive amounts of physician shopping and very little continuity of care. In March of 1982 the State of Utah received a "Free Choice of Provider" Waiver from the Department of of Health and Human Services. This Choice of Health Care Delivery Program has been operational, in the four highest populated counties of Utah, since July of that same year.

Utah's program provides Medicaid recipients with a choice of a HMO (Health Maintenance Organization) or a primary physician of their choice who is the "gatekeeper" of their care. The primary physician is responsible for continuity of care by doing all the appropriate referring to specialists, labs, x-rays, and hospitals. When the client enrolls in Case Management, the primary physician's name appears on his/her medical ID card. If possible, the specified physician should always be called prior to seeking emergency care to ensure appropriate use of the Emergency Room.

The preliminary results of case management show a significant reduction in the number of physicians used, pharmacy claims and emergency room utilization.

Specific Statistical Data, Average/Per/Client
Salt Lake County Case Management

Category of Claim	1st Quarter 1982	1st Quarter 1983	% Change +-
Number of ER (Emergency Room) Claims	.294	.198	(36.6%)
Pharmacy Claims	4.280	3.770	(12.0%)
Number of Different Physicians	1.470	1.100	(25.0%)

By reducing the number of different physicians the continuity and quality of care is improved. The decreased number of ER visits shows a greater dependency upon the primary physician which also reflects upon the quality of care.

The Estimated Cost Savings From The First Year of Waiver Implementation:

	Per/Recipient	State Wide
Case Management (3.4% savings)	$ 32.00	$928,000.00
HMO (FHP)	$352.80	$643,198.00
	Total	$1,571,198.00

After subtracting $296,555 in administrative expense the total savings for the first year is $1,274,643 or $4.3 saved for every $1 spent.

The Utah Division of Health Care Financing has found its program of "Freedom of Choice" has been a cost saving measure. But, of even greater importance, is that we feel we are improving the quality of care for Medicaid recipients. This is expressed in less physician and pharmacy shopping and better continuity of care. This human concern for the quality of health care provided is why our program has the support of a broad range of special interest and professional groups.

Scott M. Matheson
Governor

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State Health Laboratory

HET-060-84

March 6, 1984

Mr. Roderick A. DeArment
Chief Counsel
Committee on Finance
United States Senate
Washington, DC 20510

Dear Mr. DeArment:

The State of Utah Medicaid program received a waiver from the Health Care Financing Administration (HCFA) regarding freedom of choice for Medicaid clients to select to receive care from a primary care physician of their choice (Case Management Program) or from a Health Maintenance Organization (HMO). The Choice of Health Care Delivery, through the Case Management Program or Health Maintenance Organization, has been operational in the four largest counties in Utah for Medicaid clients since July 1982.

The high cost of medical care, with no controls for the recipient and complete freedom of choice, creates very expensive health care. Many Medicaid clients use multiple providers for their care; also, clients were unable or unwilling to find a doctor who would take complete charge of their care. Therefore, we saw considerable use of emergency services and excessive amounts of physician shopping and very little continuity of care.

Our Case Management Program provides Medicaid recipients with a primary physician of their choice who is the "gatekeeper" of their care. The primary physician is responsible for continuity of care by doing all the referring to specialists, labs, x-rays, and hospitals.

This program has accomplished a reduction of hospitalization, non-essential emergency room use, duplication of lab and x-ray services, and has reduced the number of specialists and multiple practitioners some clients see.

When the client enrolls in Case Management, the primary physician's name appears on his/her medical ID card. If possible, the specified physician should always be called prior to seeking emergency care. The primary physician or the doctor on call can make an assessment of the type and place of treatment required. The use of this procedure avoids unnecessary and inappropriate use of the emergency room.

The primary physician is responsible for all referrals to specialists, thus ensuring entry to the appropriate specialty. The continuity of care

An Equal Opportunity Employer

is maintained and duplication of costly health care resources is reduced. The use of a referral form was specifically designed to facilitate information exchange. A copy of this form comes to Medicaid, which enables the State to track the number of referrals from a particular physician.

The preliminary results of case management show a significant reduction in the number of physicians used, lab fees charged and emergency room utilization by recipients.

An alternative program available for Medicaid clients to receive medical care, in addition to the Case Management program, is enrollment in a health maintenance organization. The Utah Medicaid program currently contracts with one HMO--FHP of Utah. Medical care received from an HMO is less expensive than medical care received in the Medicaid fee-for-service sector. Enrollment in FHP has increased from 5,000 to 7,000 clients since July 1982.

We have included a copy of Utah's Extension of "Freedom of Choice" Waiver request that can be used as written testimony. Estimated savings realized from the Case Management and HMO programs are contained on pages 2 to 5 of the waiver request.

The Utah Division of Health Care Financing has found its program of "Freedom of Choice" has been a cost saving measure. But, of even greater importance, is that we feel we are improving the quality of care for Medicaid recipients. This is expressed in less physician and pharmacy shopping and better continuity of care. This human concern for the quality of health care provided is why our program has the support of a broad range of special interest and professional groups. (See the Utah Issues letter in the waiver request).

As the State Medicaid Director, I, or members of my staff, would appreciate the privilege of testifying before your Committee. We are excited about the progress the State of Utah is making in our Medicaid programs.

Sincerely,

Sharon G. Wasek

Sharon A. Wasek, Director
Division of Health Care Financing

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Enclosure

EXTENSION OF "FREEDOM OF CHOICE" WAIVER

A. MEASURES OF COST EFFECTIVENESS

The high cost of medical care with no controls for recipient utilization, and complete freedom of choice creates very expensive health care. Many Medicaid clients use multiple providers for their care, also clients are unable, or unwilling, to find a doctor who will take complete charge of their care. Therefore, we see considerable use of emergency services, and excessive amounts of physician and pharmacy shopping and very little continuity of care.

Our Case Management program provides Medicaid recipients with a primary physician of their choice who is the "gatekeeper' of their care. The primary physician is responsible for continuity of care by doing all the referring to specialists, labs, X-rays, hospitals and pharmacies.This will accomplish a reduction of hospitalization, non-essential emergency room use, duplication of lab and X-ray and the many specialists and multiple practitioners some clients see.

When the client enrolls in Case Management, the primary physician's name appears on his/her medical ID card. If possible, the specified physician should always be called prior to seeking emergency care. The primary physician, or the doctor on call, can make an assessment of the type and place of treatment required. However, in a life-threatening situation, or when the client has the need for immediate medical care, he/she is instructed to go to the emergency room. Treatment will be provided and the hospital will notify the primary provider within twenty-four hours. The use of this procedure should help avoid unnecessary and inappropriate use of the emergency room.

The primary physician is responsible for all referrals to specialists, thus ensuring entry to the appropriate specialty. The continuity of care is maintained and duplication of costly health care resources is reduced.The use of a referral form (see Attachment #1), which was covered extensively in provider training, was specifically designed to facilitate information exchange. A copy of this form comes to Medicaid, which enables the State to track the number of referrals from a particular physician.

Under the waivered program, the recipient, upon eligibility determination, selects one of the following:

1. HMO (Health Maintenance Organization), where reimbursement for all medical care provided is based on an at-risk capitation rate (premium per patient per month).

2. An IPA (Independent Practice Association), where the providers are paid on a capitation rate. Referrals are made by primary provider, with some risk sharing assumed by the primary provider.

3. Case Management, which is based, at present, on fee-for-service reimbursement with the client choosing one physician provider who would be responsible for his/her care. The State will share part of the cost-savings as an incentive to control costs. The primary physician will do all of the referring, but not be responsible for payments to specialists, labs and other medical services.

The choice of health care delivery is accomplished when the client is interviewed by a Health Program Representative (HPR) in the Department of Social Services Community Operations office. After the client applies for and is certified for Medicaid assistance, the HPR assists the client in making a selection, as well as educating the client toward better continuity of care.

The "Choice of Health Care Delivery", with the Case Management, HMO, and IPA programs, provides Medicaid recipients with a primary physician or group of physicians of their choice who are the "gatekeepers" of their care. The primary physician is responsible for continuity of care by doing all the referring to specialists, labs, X-rays, and hospitals. This will accomplish a reduction of hospitalization, nonessential emergency room use, duplication of lab services, X-rays, and the many specialists and multiple practitioners some clients see.

The preliminary results of case management show a significant reduction in the number of physicians used, lab fees charged and emergency room utilization by recipients. It is our desire to see case management continue to expand state-wide, and develop a system to assist both the state administrators and the providers with the type of information necessary to continue improvement on the overall effectiveness of the program.

Estimated Costs and Benefits

The following are the projected costs saved by the introduction of case management and FHP (HMO) in Salt Lake County. The comparison is made between the first quarter of 1982 (January - March) to the first quarter of 1983.

These projected savings are then applied to the State of Utah and then the Federal AFDC funds to predict the possible savings potential. The huge possibilities of applying the Utah system nationally create an overwhelming need to evaluate and specifically define the areas of Utah's Case Management where the savings occur.

Estimated Savings From Case Management

Due to the phased-in implementation schedule, there is insufficient data to evaluate Weber, Davis and Utah Counties' case management statistics. The following data and estimations are from the largest county, Salt Lake County, where the most accurate data is available. The estimated totals include only Case Management eligibles, no nursing home, Aid to Families, Aid to the Disabled, or General Assistance categories.

	1st Quarter 1982 Jan 1 to Mar 31	Adjusted 1982 For Inflation 8.88% (Utah Annual Income)	1st Quarter 1983 Jan 1 to Mar 31
Total Medicaid Claims Paid	$3,035,439.00	$3,304,986.00	$3,199,182.00

Difference Between 1982 Adjusted and 1983 Estimated Savings Per Quarter $105,804.00

X 4

Per Year. $423,216.00

% Decrease in Medicaid Payments. 3.4%

$ Decrease Per Client/Per Year (13,414 1982 Ave Monthly For SLC) $32.00

HMO (FHP Savings Over Fee For Service - AFDC Category Only

	Fee For Service	HMO (FHP)
Cost Per Client FY 1982	$ 938.46	$ 570.80

$938.46
570.80
Savings Per Client/Per Year $367.66

	FY 1982	FY 1983
Total Enrollees With FHP	4823	6646

6646
-4823
Additional FHP Enrollees in 1983. 1823

X $367.66

Total Additional Savings for 1983 FHP Enrollees. $670,244.18

Projected Costs Saved Nationally

As demonstrated in Salt Lake County, the implementation of a Case Management program resulted in a 3.4% reduction in payments. If we apply this figure to the State of California AFDC payments, the savings are very significant. Figures are from national Quarterly Public Assistance Statistics, Department of Health and Human Services, January-March and July-September 1981.

Average monthly payments to California AFDC.	$216,970,180
% decrease in payments.	x 3.4%
Average monthly savings	7,376,986
	x 12 months
Annual AFDC payments savings in California	$ 88,523,832

In applying this process to the National Government as a whole:

Average AFDC Monthly payments	$1,083,205,650
% decrease.	x 3.4%
Average monthly savings	$ 36,828,992
	x 12 months
Annual AFDC Federal Savings	$ 441,947,904

Source: Quarterly Public Assistance Statistics, Department of Health and Human Services, January-March and July-September 1981

Special Features of Target Populations

As the waivered program continues to expand state-wide, the following additional recipient populations will be added.

1. Rural Population: The AFDC population in rural Utah is in cities of less than 25,000. These rural population centers are geographically scattered over an extremely large area, with 95% of the entire rural population having access to primary care.

2. Minority Composition: The State of Utah's population is predominantly white; however, in certain areas of the State there are high concentrations of minorities--in particular, hispanics and American Indians.

	Number	% of Total Pop.
Total Population (1980 figures male and female combined)	1,459,010	100%
White	1,358,196	93.1
Black	9,053	0.6
American Indian	18,042	1.2
Asian	18,078	1.2
Hispanic	55,641	3.8

Source: Utah Department of Employment Security, Labor Market Information Services.

Potential Savings Statewide (45,429 Eligible Clients) $1,453,728.00

Although the statistics are quarterly, the data is compared over a year's time. Thus the full 8.88% inflation rate is used instead of the 2.22% Quarterly Rate.

Actual Number of Clients Enrolled in Case Management in Utah, Davis, Weber & Salt Lake Counties	29,000
Dollars Saved/Client/Year.	x $32
Estimated Total Savings Per Year in Case Management	$928,000
Estimated FHP Savings Per Year	643,198
Total Gross Savings FHP/Case Management . .	$1,571,198
Less Administrative Costs Including 10 Full Time Case Management Reps, 50% of one Secretary and 20% of Carol Thomas' and Ed Furia's Time.	- $296,555
Estimated Total Net Savings of "Choice of Health Care" in Utah.	$1,274,643
Divided by Administrative Expenses.	$296,555

Equals $4.3 saved for every $1 invested.

All figures include all Medicaid payments except nursing home.

B. MEASURES OF EFFECT ON RECIPIENT

The State of Utah, Division of Health Care Financing has one of the most advanced Medical Management Information Systems (MMIS), with a subsystem, Surveillance, Utilization Review System (SURS). This makes it possible to track the clients and providers utilization of Medicaid. The Physician Referral Form (Attachment #1) also provides information as to the practice of providers sending clients to specialists.

Statistical data from Salt Lake County since the enactment of the Waiver shows a definite decrease in utilization by the client (see Attachment #2). The emergency room use is the most dramatic, with a 36.6% decrease. There were no programs in place to account for this decrease other than Case Management.The program has been supported by the Welfare Rights groups and they are again supporting us to go state wide with our Case Management Program (See Attachment #3)

The case managers in the Field Service Offices have served as educators as well as a liaison for client and provider regarding the Medicaid program. Their one-to-one contact with the client gives them an excellent opportunity to help the client to learn what represents good medical care and the importance of continuity of care.

The complaints are rare concerning the clients' access to and quality of care. The Case Manager can assist him/her to change to another provider who may be more accessible or provide the type of care the client prefers. The Case Managers see every new Medicaid recipient and, at a minimum, at the time of annual review, all those coming in for review. When a recipient needs to change providers, he/she must return to the Case Manager to complete a new Health Care Delivery Selection form (Attachment #4). This enables the Case Manager to again do education and assist the client in any way necessary. They are also available for any problems the recipient may encounter in Medicaid at any time throughout the year.

C. IMPACT OF THE PROGRAM

Utah has been very fortunate in the fact that no litigation has occurred because of Case Management. A tremendous amount of groundwork was laid with physicians previous to implementation of the Case Management program. This included winning the approval of the State Medical Society (see Attachment #5) on the program and on the brochure that was sent to all physicians. The returned portions of the brochures were compiled into a list of available physicians willing to serve Medicaid under Case Management. When a client, assisted by the Case Manager, did not have a primary physician, the list was used to help the client find a physician willing to accept a Medicaid client. The number of physicians willing to work with the program has increased. Frequently contact is made with the Program Director by the providers concerning their clients. The majority feel much more comfortable with the program and would rather treat the Medicaid client as the primary physician than just treating an unknown.

D. RATIONALE FOR EXTENSION

The State of Utah feels very committed to the Case Management program. Our cost savings and projected savings makes the program very cost-effective as well as giving better continuity of care to the Medicaid recipient. We need an extension of our Waiver to continue to work in the urban area, but we are also very desirous of taking the program state-wide.

Our objective is to improve the quality of health care in the rural areas, reduce the cost of Medicaid services and increase the competition of quality rural Medicaid providers.

POPULATION TO BE SERVED

Description

There are 58,137 Medicaid recipients in Utah. After subtracting the General Assistance group of 2,708 and the Nursing Home group of 4,982, there are 50,477 eligible recipients for the "Choice of Health Care Delivery" program in Utah, of which about 90% are AFDC (Aid to Families with Dependent Children) with the remaining 10% in CC (Care for Children) and OAA (Old Age Assistance).

Source: Utah State Department of Health, Division of Health Care Financing (average monthly figures for FY 1982-83 preliminary report July 29, 1983).

Of the 50,477 eligibles only 7600 receive health care through the State's only HMO (FHP), which is limited to service in only three of twenty-nine counties - Davis, Weber, and Salt Lake. An estimated 29,760 of the same group of eligibles are, or will be, enrolled in Case Management or the Primary Physician concept. This leaves 13,117 who do not have any affiliation with the Primary Care programs as administered by Case Management, HMO's and IPA's and who live in Rural Utah.

This group of 50,477 eligible primary care Medicaid recipients is the target group for the proposed use of the HCFA demonstration grant. Approximately 80% of this group are in the area of the State called the Wasatch Front, Weber, Davis, Salt Lake, and Utah counties and are currently participating in the Case Management program. The remaining 20% are spread over the remaining 25 Utah counties in small cities and towns of 20,000 or less people. This remaining group will begin to participate in the Case Management program as it expands statewide

Rationale For Population Selection: The 50,477 AFDC, CC, and OAA Medicaid recipients account for approximately 52% of the FY 1982-83 state Medicaid budget (exclude nursing home expenditures).

Total Medicaid Services	$123,034,000
AFDC, CC, OAA Expenditures	$ 63,977,680

Source: Utah State Department of Health, Division of Health Care Financing Preliminary FY 1982-83 report July 29, 1983.

If, by going to the Primary Care concept statewide, a one or two percent savings is realized, it could be significant, and a five percent reduction in expenditures as predicted, could reduce the state's Medicaid budget by $3,198,884 a year.

Since the granting of the state's "Freedom of Choice Waiver", the entire Medicaid population other than the GA and institutionalized groups may be placed, according to their choice, into one of the three categories of the waiver - Case Management, HMO, or IPA. The State, therefore, has a population defined with which it can implement the Primary Care concept without any difficulty.

Specific Recipient Medicaid Categories Targeted

Category	Number of Recipients
AFDC	45,429
OAA	4,038
CC	1,010

Other Classes of Payors

The target population will not include any other class of payers, the only payer will be the State Medicaid program.

Problems of the Target Population in Receiving Care

Limited number of HMO's and IPA's: There is only one HMO in Utah, FHP which is in Weber, Davis and Salt Lake Counties. There are no IPA's at this time.

Population Distribution: 13,117 of the Medicaid recipients eligible for the Primary Care concept live in rural areas in population centers of less than 20,000. The logistics to serve this group of recipients have prevented the implementation of the case management concept statewide. However, this is the specific target group for the Rural Health Network, which is the approach that will be used to expand the Case Management Program into the rural areas of the State..

American Indian Population

One specific area of concentration for the proposed grant project is the American Indian population in Utah. There are two tribal organizations of major proportion in Utah--the Ute tribe in Duchesne and Uintah Counties, with about 2,500 members and the Navajo tribe in San Juan County with approximately 6,000 members. Both groups historically have high unemployment and a high dependence upon state health programs. Utah Health District 7A, which is San Juan County has about 1,000, or 5% of its total population enrolled in Medicaid. These figures are extremely large when less than 4% of the total state population is enrolled in Medicaid.

We feel that a major effort needs to be extended to the American Indian population of Utah for a well-managed health care program. The proposed Case Management Representatives in both of the above areas will have a smaller total population, but a higher concentration of Medicaid recipients, many of which are native Americans. Also, it is estimated that 40% of San Juan county is below the poverty level.

Source: Medical Assistance '82, FY 81-82, Utah State Department of Health, Utah Affirmative Action Information, February 1981, Job Service.

State-of-The-Art Resolution

1. ORGANIZATIONAL STRUCTURES - CURRENT: As of November 1, 1983, there are twelve health districts in the State of Utah. These are multi-county in the rural areas, and partial county in the metropolitan Salt Lake City area. These health districts do not, under the Utah system, administer any Medicaid funds. They are, however, involved in immunizations, pregnancy screenings, and other state and federally funded programs.

   In addition, there are also three rural health clinics located in non-populace areas of Loa-Bicknell, Duchesne, and Green River. They provide primary health care to indigent and low income residents. Funding for these rural health facilities comes from both state and federal agencies with no Medicaid administration responsibilities whatsoever.

   At this time, Medicaid is administered in rural Utah on a fee-for-service basis through qualified providers, i.e. physicians, specialists, nursing homes, hospitals, and other designated entities.

2. Services Provided: The State of Utah provides the following categories of care for AFDC Medicaid recipients:

   Physician services
   Inpatient Hospital services
   Home and rural health services
   Prescribed medications
   Dental care
   Lab and X-ray services
   Podiatry care
   Eye examinations and eyeglasses
   Speech and audiology services
   Physical Therapy
   Psychology services
   Mental health services
   Family planning services
   Early periodic screening, diagnosis, and treatment (EPSDT)
   Medical supplies, prosthetic devices, and special appliances
   Medical transportation

   Special surgery such as open heart, organ transplants, etc. are referred to the major metropolitan hospitals in northern Utah.

3. Administrative Systems: Medicaid in rural Utah is administered on a fee for service basis, with the providers billing the State Medicaid Agency directly and these claims being paid on a weekly basis as submitted.

Approach for Problem Resolution

1. Rural Health Network: The purpose of the Rural Health Network (RHN) is to provide case management through primary care physicians/ providers and/or HMO's or IPA's. This will be accomplished through the formation of an administrative agency consisting of a project director and five Case Management Representatives. The Case Management Representatives will first enlist family practice physicians as primary care providers, then assist AFDC and other case management eligibles in the selection of one of the family practice physicians as their case manager. Additional responsibility following this initial formation of the case management system will be to assist, promote, and market HMO's and IPA's in areas with populations large enough to support capitated programs. Another important continuous function of the Rural Health Network is the training of both providers and clients in ways to improve quality and reduce costs.

   The following cities are targeted: Logan, Tremonton, Brigham City, Tooele, Vernal-Roosevelt, Price, Monticello, Delta, Cedar City, St. George, Gunnison, Richfield, Panguitch, Kanab.

   The Project Director's function would be to direct and oversee the RHN's operation including: claims processing, record keeping, M.I.S., direct supervision of the rural case management

representatives, developing marketing plans for the creation of HMOs and IPAs in the target areas, and creating training programs for providers and clients.

> The goals of the Rural Health Network are to (1) get 90% of all eligible AFDC clients enrolled in case management and, (2) at the end of the 3-year demonstration period have 20% of those clients in capitated programs such as HMOs or IPAs. These goals are reasonable as similar results have already been achieved in the four metropolitan counties during the initial 2-year implementation period.

The Division of Health Care Financing in Utah is desirous of continuing the Case Management Program and request our "Free Choice of Provider" waiver be extended for at least the next two years, beginning March 24, 1984. This will prevent any break in continuity of the program.

24-08 55

UTAH DEPARTMENT OF HEALTH
MEDICAID FORM

PHYSICIAN REFERRAL FORM

DIVISION OF HEALTH CARE FINANCING
CLIENT UTILIZATION CONTROL PROGRAM

MAIL TO:
Client Utilization Control Program
Room 440
P.O. Box 510167
Salt Lake City, Utah 84151

The recipient named below requires medical services in addition to those that I provide. I am, therefore, referring the recipient to the practitioner named below, as discussed with the recipient.

RECIPIENT NAME _____ _____
Last First Middle

MEDICAID ID NUMBER: _____

CONSULTANT REFERRED TO: _____ _____
Practitioner Name (Please Print)

_____ _____
Address (Please Print)

REASON(S) FOR REFERRAL:

- ☐ Opinion Only
- ☐ Concurrent Care
- ☐ Referred for Assumption of Care

DIAGNOSIS (ES) and/or CONCERNS:

Referring Provider Name, Address and Telephone	
Referring Provider License No.	Date Referral Authorized

_____
Referring Provider Signature

©1984 by Client Utilization Control Program

*NOTE: TO CONSULTANT
To assure prompt payment when billing for your services, assure that the Referring Physician License Number is entered in the "Referring Provider License Number" field on your HCFA-1500 or Inpatient Hospital invoice. See Attachment E of your Medicaid Provider Manual.

ATTACHMENT #2

Specific Statistical Data, Average/Per/Client
Salt Lake County Case Management

Category of Claim	1st Quarter 1982	1st Quarter 1983	% Change +-
Number of Physician Office Visits	2.83	2.23	(21.2%)
Number of ER Claims	.294	.198	(36.6%)
Pharmacy Claims	4.28	3.77	(12%)
Number of Different Physicians	1.47	1.10	(25%)

UTAH ISSUES

Statewide Information System on Social Issues

(801) 521-2035

231 East 100 South
Lower Level
Salt Lake City, Utah 84111

December 5, 1983

Carol Thomas
Utah Department of Health/Health Care Financing
150 West North Temple
Salt Lake City, Utah 84103

Dear Ms. Thomas:

As a representative of a community-based organization, I have monitored the development of Case Management in the target areas for the past year and found, generally, that it has worked to the benefit of Medicaid recipients. I appreciate the responsiveness of your agency to our concerns.

Utah Issues Information Program was incorporated in 1972 as a state-wide mechanism to address issues pertaining to Utah's low-income population. The basic philosophical tenets under which we operate are as follows:

1) that low-income needs are inadequately represented in governmental decision-making. However, needs of low-income people can be addressed effectively through recognized democratic processes with assistance from those who understand the decision-making process;

2) that welfare recipients and other dependent poor want to work and will become economically independent if programs are designed to facilitate, rather than discourage, this self-sufficiency. The clear goal of social programs serving the low-income should be to eliminate existing barriers to economic independence;

3) that governmental programs designed to aid the poor will be more successful and more cost-effective if those to be served are involved in the planning and monitoring of those programs; and

4) that the quality of life for all citizens is improved when the needs of the disadvantaged are addressed adequately.

As federal and state resources to provide the poor health care constrict, we are supportive of alternative modes of delivery that maintain quality of care and encourage fiscal accountability. We would hope to be able to continue to relay and represent concerns of low-income participants to you and other decision-makers.

Our and your objectives happily coincide in the matter of Case Management. Be assured that we will follow any expansion with interest.

Again, I appreciate your responsiveness to concerns raised by and on behalf of Medicaid recipients.

Sincerely,

Bill Walsh

Bill Walsh, Assistant Director

Senator DURENBERGER. Let me start with the issue that some of you raised—which was 1903—and I will just read from the Blue Book and ask you how we are going to handle this in places like Michigan and Missouri.

It says:

> Proponents of the deletion of the 1903(m) waiver authority argued that allowing the Secretary to waive these requirements might lead to contracting abuses similar to those which occurred during the Medicaid prepaid health plan scandal as experienced by California in the 1970s. During that period, lax contracting controls resulted in discriminatory marketing practices, denied access to needed services, and other problems.

Now, I know that wouldn't happen in Michigan, and I know that wouldn't happen in Missouri, and so forth, but folks are concerned about medicaid bills, if you will, in the form of a prepaid plan. If you come to my State, with which you are all familiar, you don't run into this kind of problem because there were seven or eight HMO's there already in the private sector, and all you would have to do in this process is buy in through medicaid, and you would never run into this problem. Why is it though that with the advantages the community has in having large populations who are willing to enroll in prepaid health plans that the community can't pick up this notion and expand it to the medicaid population, expand it to employer-based populations, and so forth. Why is it that the community doesn't solve your problems rather than our having to solve the 1903 problem by eliminating the 75 percent?

Mr. ALLEN. I have been contracting with HMO's since 1972, and I have been hearing that same old song about the problems in California since 1972. And I think they have taken a specific problem that occurred early in the development of HMO's relationships with medicare and medicaid, and they have tarred the States with the same brush, and it is wrong. We had an HMO licensure law in Michigan before they had Federal standards, and we have been monitoring it carefully, and we have more people as a percent of our population than the private sector does. We have, as I said, over 12 percent of our medicaid population in an HMO right now, and I think in the private sector—the Fords, the General Motors, and so forth—theirs is less than 4 percent.

So, I think the California experience is not applicable in today's marketplace at all.

Senator DURENBERGER. But why would you have a problem in Wayne County when you have all those auto workers ready to sign up for the HMO's?

Mr. ALLEN. I think because the union contracts had some specific language about the ability to encourage market, coerced their membership into that kind of a health care delivery system.

Senator DURENBERGER. Very good. The reality is that the United Auto Workers have decided that you can only go to a captive HMO. Right? Is that good for Wayne County and its poor and its economically disadvantaged? Why should I change the rules here when these guys that are getting paid $6,000 for their health insurance are restricting access in Wayne County? Isn't that a Detroit problem and a Michigan problem, rather than my problem?

Mr. ALLEN. Well, it is except that I think the union and management are on the same track together now, and they are trying to

discourage what you have said has become a habit over time, and that is to restrict them to one HMO. So, I think that problem is going away. On the other hand, Federal and State groups like ours that are trying to maximize HMO use are inhibited by the current law, and we would like it changed. We think we are big boys and we can monitor it.

Senator DURENBERGER. Yes, but you can see where I am stuck. I am trying to foster choice and competition, and you are doing a great job for me, for all of us, and doing it with a medicaid population, and you are giving people in your community an opportunity to expand choice through a variety of health plans. But you still are being staffed by a large portion of the employed population in that community.

Mr. ALLEN. But a lot of the employed population doesn't live where the medicaid population lives, and there are vast pockets of underserved areas where there are no large employer amounts of people, and that is our problem.

Senator DURENBERGER. OK. Maybe you can expand on that particular phase of it for me but not just now. We are going to have to take a 5- or 10-minute recess, so I can go vote.

[Whereupon, at 10:55 a.m., a short recess was held.]

AFTER RECESS

Senator DURENBERGER. Let me just continue a little bit on the 1903, Sharon. Jack Danforth is in a markup, I think on Commerce, and he wanted to be here to say hello to you. Do you want to add some comments?

Ms. MARCUM. Yes, I would, Mr. Chairman. First of all, I would reiterate what Paul said about the service area. Where the client lives is very important, and again, we have the same problem—where we have highly concentrated population areas of our medicaid clients, and we do have providers there serving them. We have used those existing fee for service providers and converted them to a prepaid financing arrangement for the medicaid client, but they exclusively offer prepaid arrangements for the medicaid client. Second, we simply don't have many HMO's in Missouri. The State has been a leader in the development of prepaid health care and hopefully that will change over the next few years, but if we had had to depend on existing HMO's, we would not have had sufficient capacity.

Senator DURENBERGER. Yes; I suppose we have the luxury in the Twin Cities of having HMO's that are—at least a number of them are—community based. They overcome the locational problem by contracting with hospitals that are in the same location or having doctor members that are in that location. When the private side prepaid plan can get there first and get itself established, it is much easier than the flip side, which is what I understand you are experiencing

But from our standpoint, there is still the problem of the people that stand in the way. It isn't just geography that stands in the way. I really meant what I said about the auto workers and the automobile companies and whoever else runs Detroit, and they are standing in the way of holding down the cost of health care and

upping the access of the poor. And somebody has to say that to them because they are not poor—they are doing just fine. There are a lot of poor in Detroit whose cost of health care—when they can get it—is being increased, not decreased, by those auto worker plans. And I just hope that changes. Does anybody else want to react to that general subject?

Ms. WASEK. We have a similar problem in Utah. We have only one HMO, but Utah is more of a rural State and so we haven't been faced with the 75-percent problem yet, but it is an arbitrary limitation, and I do think there are other alternatives to achieve the same purpose in terms of standards and quality assurance and certification procedures which would get at the medicaid mill problem without putting an arbitrary limit that hurts States that do not have any kind of a private PPO or HMO. We have a concern about another part that maybe you are getting to, and that is the 30-day disenrollment question. We just feel that without the ability to ask medicaid people to participate at a somewhat longer period of time—as everyone else does—State employees, private industry, and so forth, and it is a year for most other employees—that it is going to be very difficult to keep the HMO's encouraged about providing care for MA clients and yet will result in their not having available to them the kind of continuity care that is part of an HMO, and we think valuable, and second, it surely will force higher administrative costs.

Senator DURENBERGER. There are probably hundreds of questions that could be asked here, but your statements cover a lot of it. When Jack was here, he talked about the problem that we are trying to resolve, and he talked about it in terms of the challenges to structure financial incentives in a way that strikes a balance between two poles—too little risk for provider practice patterns to be altered significantly and too much risk for providers to be induced to participate. And he talked about New Jersey and the example of the $7 office visit and the result was that a lot of people are utilizing expensive emergency rooms.

Can any of you relate for us from your experience how you have changed some of those disincentives, utilizing the program waivers that you are involved in?

Mr. ALLEN. I would like to speak to that, yes. I think frankly that the problem that Jack addressed and you are addressing now is indemic—it is a national problem.

And in Michigan, because of our high unemployment for several years now, we addressed the problem earlier, and we find—I wasn't being facetious when I said there is a shortage of patients—there are. There is a surplus of health care delivery capability out there. And so, by using the waiver process, the HMO incentive and the like, we have encouraged our physicians to participate more by giving them a capitation fee and then paying them fee for service over and above that. And we have also given them an incentive by saying that if you keep our patients out of the hospitals, then we will share the savings with you through an increase in your fees. Now, this then encourages them to participate.

We have also told the client that, as a result of their joining an HMO or primary care network, they won't have to pay any copayments or deductibles for the services that they currently have to

pay under the fee for service system. No copayment for drugs. No copayment for vision, and the like. And this is an incentive to both sides of the issue to join in this kind of an arrangement—receive accessible care at a reasonable price.

Senator DURENBERGER. Yes; do you have a comment?

Ms. MARCUM. Yes, I do, Mr. Chairman. In 1981 the Missouri medicaid program was totally out of control in terms of spending—our cost increased 37 percent in 1 year, and it was a year when the State was almost bankrupt due to high unemployment and lagging State revenues.

We immediately implemented over 170 different cost containment measures for short-term budget savings, which we had to do. We recognized that that was not the long-term solution, but that we had to change the basic incentives in the system. We simultaneously sought the waivers in order to begin this project, and we still feel very positively that it is the best investment a State can make.

Senator DURENBERGER. OK. Ms. Wasek, let me ask you a question about nursing home waivers. Utah is unique in that it has a surplus of nursing home beds. And I understand you have applied for a waiver to enter selective contracting for nursing home care. Could you tell us something about the waiver and how it would fit into the State's overall plan for long-term care?

Ms. WASEK. Mr. Chairman, we have not applied for a formal waiver yet. We have developed one, and are in the process of negotiating with our health care association in Utah, looking at that as an option toward moving off of the flat-rate reimbursement system. And it is a way in which we feel we could improve the quality of care of nursing home patients. We see it as a negotiated contract where both parties can negotiate both in terms of deficiencies related to continued certification—how many would be allowed—as well as the provider can come in and be reimbursed at a fee that would meet their needs. You could guarantee a certain volume which I think has some tradeoffs for it—it is a feasible approach.

Senator DURENBERGER. OK. Thank you all very much. I appreciate your being here, and I am particularly grateful for the volume of testimony that we now have as part of the record, thanks to your advance work.

Our next witness is Carolyne Davis, Administrator of the Health Care Financing Administration, Department of Health and Human Services, Washington, DC.

Carolyne, thank you for being here, and thank you for your patience. I apologized earlier for the way the day has been goofed up, and I will repeat that because I know you are under time limitations.

STATEMENT OF CAROLYNE K. DAVIS, PH.D., ADMINISTRATOR, HEALTH CARE FINANCING ADMINISTRATION, DEPARTMENT OF HEALTH AND HUMAN SERVICES, WASHINGTON, DC, ACCOMPANIED BY ELMER SMITH, DIRECTOR OF OFFICE OF ELIGIBILITY POLICY

Dr. DAVIS. That is fine, Senator. If I could just begin by introducing Mr. Elmer Smith who has joined me at the table. He is the Di-

rector of the Office of Eligibility Policy. Mr. Smith has been with the medicaid program since its inception in 1965, and I think he will lend a great deal of expertise to our discussions this morning.

Let me just briefly highlight my testimony. In terms of implementation of the waiver program, I think we acted promptly after the initial passage of the legislation by Congress. We waived the proposed rulemaking process and published the regulation in October 1981 as an interim final with a comment period. And in the development of that regulation, we tried to afford the States a great deal of opportunity for flexibility and innovation in development of their particular program guidelines, and tried to minimize our Federal role in terms of being overly prescriptive.

In terms of the processing of the waivers, the waivers are generally submitted by the States to the HCFA regional office. Those requests are reviewed at that level and then they are forwarded, along with the regional office's recommendations, to the Central Office for further review. Final approval or disapproval of the applications are generally made by myself as the administrator, although a disapproval must have the concurrence of the Secretary.

Waiver requests can also be submitted directly to the Secretary by either a Governor or a State cabinet level official, and those procedures are spoken of as being on a fast track and are reviewed in the central office, and then the notice of approval of a waiver is submitted back to the Secretary and are made by the Secretary back to the Governor.

Waiver requests must be approved or disapproved or we must request additional information within a 90-day period of time from the receipt or else that request would be deemed granted. We have been able to meet those deadlines. I can just highlight the fact that we have granted some 37 waivers in 16 States now under the freedom of choice provision. I think the most frequent request has been for waivers of case management purposes, which typically utilizes family practice physicians, internists, pediatricians, or physician extenders in order to deliver primary care services. They provide, however, for a full scope of health care including the provision of specialized services. We have 23 of those waivers for case management that have been approved. In addition, we have approved nine waivers to restrict the choice of providers and four waivers to share cost savings with the State's medicaid beneficiaries, and one waiver for a locality to act as a central broker.

My testimony does highlight a number of the States in terms of the kinds of materials that they have submitted to us. Regarding the types of waiver requests we have received, I think that the States have spoken very eloquently to that, and so I would just point out that that information is included as well. Our experience has been—in terms of implementation of the waiver authority—that the States often require more time than they had initially anticipated in implementing their waivers. Consequently, a number of States have submitted waiver requests, and then they have subsequently withdrawn those requests because they find that they need more time to think out the design of the program and perhaps even to work with the provider community to gain stronger provider community support. We are required by statute to submit to Congress by September 1984 a report on the waivers that have

been granted under this section, and we will be doing so. I would like to point out also that we are providing monthly reports to the committee staff on an informal basis regarding what waivers we are approving and where the others are in the system. In terms of monitoring the waivers, we do that in a number of ways. The regional offices are responsible for the first-line review, and they also review the waiver process as part of their annual State assessment. In addition, we do have some special reviews that are going on in particular States where there is an aspect of the program—such as the California competitive bid system—that we are particularly interested in. I have been receiving monthly reports from some of these. Also, we performed a number of onsite assessments in some States that have the waiver programs. We have a contract for an overall evaluation of our waiver program in relationship to the freedom of choice waivers. We contracted with James Bell & Associates, Syracuse University, the Urban Institute, and the National Governors Association to review and evaluate a number of issues that relate to the freedom of choice waivers. We will be looking at the impact of the changes on health care costs and utilization, as well as consequences of the 1982 limitation on the 1903(m) HMO waiver authority. Our preliminary report will be due in December 1984, and then the final report in December 1986. In addition, we funded several States for individual State evaluation efforts, including Michigan which mentioned the fact that they have such an award. I expect we will be awarding several more in the near future.

I think the waivers have not been in effect long enough to provide data that is conclusive regarding cost effectiveness. However, we strongly support the flexibility that has been provided by the States in this waiver provision, and we do feel that the waivers, particularly those in the case management area, will assure continuity of care to medicaid beneficiaries in the programs.

And I think that is an equally important one. It is clear that we are optimistic and enthusiastic about the efforts that the States have undertaken in this effort. It seems to me that it is an important movement for them to think through the various options that they hold, rather than reduce eligibility. I believe that States are finding that they can restructure some of their programs to decrease some of the excessive utilization by the use of these case management or freedom of choice waivers. And we think that that will indeed revitalize their medicaid delivery systems.

Thank you. I would be happy to answer your questions.

Senator DURENBERGER. Yes. Thank you very much.

[The prepared statement of Carolyne K. Davis, Ph.D. follows:]

STATEMENT OF

CAROLYNE K. DAVIS, PH.D.

MR. CHAIRMAN AND MEMBERS OF THE SUBCOMMITTEE, I AM PLEASED TO BE HERE TODAY TO DISCUSS WITH YOU IMPLEMENTATION OF THE MEDICAID FREEDOM OF CHOICE WAIVERS.

BACKGROUND

ONE OF THE PRINCIPLES UNDERLYING THE MEDICAID PROGRAM HAS BEEN "FREEDOM OF CHOICE" OF THE BENEFICIARY -- THE RIGHT OF THE INDIVIDUAL RECEIVING MEDICAID BENEFITS TO SELECT HIS OR HER OWN PHYSICIANS AND OTHER PROVIDERS AND SUPPLIERS OF HEALTH SERVICES WHO MEET REASONABLE STATE QUALIFICATION STANDARDS. THE PURPOSE OF THE PROVISION WAS TO AVOID A DUAL MEDICAL CARE SYSTEM IN WHICH MEDICAID BENEFICIARIES RECEIVED CARE FROM ONE SET OR TYPE OF PROVIDERS, WHILE OTHERS RECEIVED CARE IN A DIFFERENT MANNER. THUS, THE FREEDOM OF CHOICE PROVISIONS WERE ENACTED TO ENSURE THAT MEDICAID BENEFICIARIES ARE SERVED IN THE "MAINSTREAM" MEDICAL CARE SYSTEM BY ALLOWING THEM TO CHOOSE AMONG THE SAME PROVIDERS OF COVERED HEALTH CARE AND SERVICES AS ARE NORMALLY OFFERED TO THE GENERAL POPULATION.

EXPERIENCE SUGGESTS THAT FREEDOM OF CHOICE IS HONORED MORE IN PRINCIPLE THAN IN PRACTICE. MANY PROVIDERS DECLINE TO SERVE MEDICAID BENEFICIARIES, AND THE POOR MUST OFTEN USE

PUBLIC CLINICS AND HOSPITALS LOCATED IN THE AREA IN WHICH THEY RESIDE.

WAIVER AUTHORITY

IN 1981, CONGRESS ENDEAVORED TO INCREASE THE EFFICIENCY OF THE MEDICAID PROGRAM BY ALLOWING STATES TO IMPLEMENT INNOVATIVE HEALTH CARE DELIVERY AND MANAGEMENT ALTERNATIVES.

THE OMNIBUS BUDGET RECONCILIATION ACT OF 1981 (P.L. 97-35) PROVIDED AUTHORITY FOR STATES TO MAKE FUNDAMENTAL CHANGES IN THE RELATIONSHIP OF MEDICAID BENEFICIARIES TO HEALTH CARE PRACTITIONERS AND PROVIDERS, INCLUDING EXCEPTIONS TO THE FREEDOM OF CHOICE REQUIREMENT AND OTHER PROGRAM PROVISIONS.

UNDER SECTION 2175 OF THAT LAW, STATES MAY ENTER INTO CERTAIN ARRANGEMENTS TO PURCHASE LABORATORY SERVICES OR MEDICAL DEVICES THROUGH COMPETITIVE BIDS. STATES MAY ALSO ESTABLISH "LOCK-IN" PROGRAMS WHICH RESTRICT FOR A REASONABLE PERIOD OF TIME THE CHOICE OF PROVIDER BY A BENEFICIARY WHO HAS OVERUTILIZED SERVICES, OR A "LOCK-OUT" PROGRAM WHICH PROHIBITS PROVIDERS WITH QUESTIONABLE PRACTICE PATTERNS FROM PARTICIPATING IN MEDICAID.

THE LAW FURTHER PROVIDES THAT TO THE EXTENT THE SECRETARY FINDS IT TO BE COST-EFFECTIVE, EFFICIENT, AND NOT INCONSISTENT WITH PROGRAM INTENT, THE SECRETARY MAY WAIVE CERTAIN FEDERAL REQUIREMENTS IN ORDER FOR STATES TO IMPLEMENT A NUMBER OF CREATIVE OPTIONS FOR DELIVERY AND MANAGEMENT OF HEALTH SERVICES. THESE PROVISIONS ARE THE ONES MOST FREQUENTLY REFERRED TO AS "FREEDOM OF CHOICE WAIVERS." UNDER THESE PROVISIONS, A STATE MAY IMPLEMENT A PRIMARY CARE CASE MANAGEMENT SYSTEM OR A PHYSICIAN SPECIALTY ARRANGEMENT, OR MAY RESTRICT THE CHOICE OF PROVIDER FROM WHOM THE BENEFICIARY CAN OBTAIN SERVICES (IN OTHER THAN EMERGENCY CIRCUMSTANCES). A STATE MAY ALLOW A LOCALITY TO ACT AS A CENTRAL BROKER IN ASSISTING MEDICAID BENEFICIARIES IN SELECTING AMONG COMPETING HEALTH PLANS. IN ADDITION, A STATE MAY SHARE WITH BENEFICIARIES IN THE FORM OF ADDITIONAL SERVICES THE SAVINGS RESULTING FROM THE USE OF MORE COST-EFFECTIVE CARE.

WHEN RESTRICTING CHOICE TO COST-EFFECTIVE AND EFFICIENT PROVIDERS, THE STATE MUST ASSURE THAT PROVIDERS COMPLY WITH STATE STANDARDS WHICH ARE CONSISTENT WITH ACCESS, HIGH QUALITY CARE, AND EFFICIENT AND ECONOMIC PROVISION OF SERVICES. FURTHER, STATES MUST NOT DISCRIMINATE AMONG TYPES OF PROVIDERS FOR ANY REASONS WHICH ARE NOT RELATED TO DEMONSTRATED EFFECTIVENESS AND EFFICIENCY IN PROVIDING SERVICES.

WAIVERS GRANTED UNDER THIS PROVISION ARE ISSUED FOR TWO YEARS, ALTHOUGH A STATE MAY REQUEST A CONTINUATION AT THE END OF THAT TIME PERIOD.

WAIVER OF HMO REQUIREMENTS

AS ORIGINALLY ENACTED, SECTION 2175 ALSO INCLUDED AUTHORITY FOR THE SECRETARY TO WAIVE THE REQUIREMENTS OF SECTION 1903(M), THE HEALTH MAINTENANCE ORGANIZATION (HMO) REQUIREMENTS. SECTION 1903(M) PROVIDES THE ONLY AUTHORITY IN THE MEDICAID LAW FOR CAPITATION PAYMENTS FOR COMPREHENSIVE SERVICES. IT ALSO ESTABLISHES ENROLLMENT AND DISENROLLMENT REQUIREMENTS FOR HMOS. THIS NEW 2175 AUTHORITY MEANT THAT STATES WOULD BE ABLE TO WAIVE HMO REQUIREMENTS TO IMPLEMENT A CASE MANAGEMENT SYSTEM, ALLOW A LOCALITY TO ACT AS A CENTRAL BROKER, SHARE COST SAVINGS WITH BENEFICIARIES, OR RESTRICT AN INDIVIDUAL'S CHOICE OF PROVIDERS. A NUMBER OF STATES SUBMITTED REQUESTS TO UTILIZE THIS WAIVER AUTHORITY, AND AS OF AUGUST 10, 1982, THE HEALTH CARE FINANCING ADMINISTRATION (HCFA) HAD GRANTED SIX SUCH REQUESTS (ONE EACH TO NEW YORK, WISCONSIN, PENNSYLVANIA, AND NEW HAMPSHIRE, AND TWO TO MICHIGAN).

IN 1982, HOWEVER, IN THE TAX EQUITY AND FISCAL RESPONSIBILITY ACT (P.L. 97-248), CONGRESS ELIMINATED THE

SECRETARY'S AUTHORITY TO WAIVE THE SECTION 1903(M) REQUIREMENTS. IN ORDER TO MINIMIZE DISRUPTIONS OF ARRANGEMENTS WHICH WERE ALREADY IMPLEMENTED UNDER THESE WAIVERS, CONGRESS SPECIFIED THAT WHERE A WAIVER HAD BEEN GRANTED AND THE WAIVERED PROVISIONS WERE IN EFFECT PRIOR TO AUGUST 10, 1982, THE LIMITATIONS ON THE SECRETARY'S WAIVER AUTHORITY WOULD NOT APPLY. THE EXEMPTION EXTENDS ONLY FOR THE PERIOD FOR WHICH THE WAIVER WAS INITIALLY APPROVED.

CONGRESS NOTED ITS UNDERSTANDING THAT CERTAIN TYPES OF ENTITIES WERE NOT SUBJECT TO THE REQUIREMENTS OF SECTION 1903(M) AND THUS WOULD NOT BE AFFECTED BY ELIMINATION OF THE 1903(M) WAIVER AUTHORITY. THOSE ENTITIES INCLUDE CONTRACTUAL ARRANGEMENTS BETWEEN THE STATE AND AN INDIVIDUAL PHYSICIAN OR A GROUP OF PHYSICIANS UNDER WHICH: (1) CASE MANAGEMENT IS THE PRIMARY PURPOSE; (2) HOSPITAL SERVICES ARE NOT PROVIDED DIRECTLY BY OR UNDER CONTRACT FOR PAYMENT TO SUCH PHYSICIAN OR PHYSICIAN GROUP; (3) THE PHYSICIAN OR GROUP RECEIVES AT LEAST 25 PERCENT OF ITS GROSS REVENUES FROM NON-MEDICAID AND NON-MEDICARE PATIENTS (THROUGH FEE-FOR-SERVICE OR OTHER REIMBURSEMENT METHODS); (4) THE MEDICAID REVENUES THAT THE PHYSICIAN OR GROUP WOULD OTHERWISE RECEIVE FROM THE ARRANGEMENT WILL NOT INCREASE MORE THAN 20 PERCENT AS A RESULT OF DECREASES IN THE USE BY BENEFICIARIES UNDER MANAGEMENT OF HOSPITAL AND OTHER COVERED

SERVICES; AND (5) PRIMARY CARE SERVICES ARE AVAILABLE ON A 24-HOUR BASIS.

IMPLEMENTATION OF WAIVER PROGRAM

THE HEALTH CARE FINANCING ADMINISTRATION ACTED PROMPTLY TO IMPLEMENT THE FREEDOM OF CHOICE WAIVER PROVISION. IN ORDER TO HAVE REGULATIONS IN PLACE AS CLOSE AS POSSIBLE TO THE EFFECTIVE DATE OF THE LAW, WE WAIVED PROPOSED RULEMAKING AND PUBLISHED THE REGULATION ON OCTOBER 1, 1981, IN INTERIM FINAL FORM WITH A COMMENT PERIOD ALLOWING FOR PUBLIC PARTICIPATION. IN DEVELOPING THE REGULATIONS, WE TRIED TO AFFORD STATES THE GREATEST POSSIBLE OPPORTUNITY FOR FLEXIBILITY AND INNOVATION IN THEIR PROGRAMS. THEREFORE, WE MINIMIZED PRESCRIPTIVE FEDERAL DEFINITIONS AND PROCEDURES IN ORDER THAT THE WAIVER AUTHORITY WOULD NOT IMPOSE RESTRICTIONS BEYOND THOSE CONTAINED IN THE STATUTE. FOLLOWING PUBLIC COMMENT, FINAL REGULATIONS WERE PUBLISHED MAY 24, 1983.

WAIVER REQUESTS GENERALLY ARE SUBMITTED BY THE STATES TO HCFA REGIONAL OFFICES. THE REQUESTS ARE REVIEWED INITIALLY AT THIS LEVEL AND THEN FORWARDED, ALONG WITH THE REGIONAL OFFICE'S RECOMMENDATION, TO HCFA CENTRAL OFFICE FOR FURTHER REVIEW. FINAL APPROVAL OR DISAPPROVAL OF THE APPLICATION

GENERALLY IS MADE BY THE HCFA ADMINISTRATOR, ALTHOUGH DISAPPROVALS MUST HAVE THE CONCURRENCE OF THE SECRETARY. WAIVER REQUESTS MAY ALSO BE SUBMITTED DIRECTLY TO THE SECRETARY BY EITHER A GOVERNOR OR A STATE CABINET-LEVEL OFFICIAL. THOSE APPLICATIONS ARE REVIEWED AT HCFA CENTRAL OFFICE; AND NOTICES OF APPROVALS OF WAIVERS SUBMITTED DIRECTLY TO THE SECRETARY ARE MADE BY THE SECRETARY.

A WAIVER REQUEST MUST BE APPROVED, DISAPPROVED, OR ADDITIONAL INFORMATION REQUESTED WITHIN 90 DAYS OF RECEIPT OR ELSE THE REQUEST WILL BE DEEMED GRANTED.

IN ADDITION TO SOME SPECIFIC STATUTORY REQUIREMENTS RELATED TO EACH TYPE OF WAIVER, STATES MUST ALSO MEET CERTAIN OTHER KEY REQUIREMENTS: THEY MUST DOCUMENT THE COST-EFFECTIVENESS OF THE PROJECT; THEY MUST DESCRIBE THE EFFECT OF THE PROJECT ON RECIPIENTS REGARDING ACCESS TO CARE AND QUALITY OF SERVICES; AND THEY MUST DESCRIBE WHAT THE PROJECT HOPES TO ACHIEVE, AND HOW THAT WOULD BE CONSISTENT WITH THE OBJECTIVES OF THE MEDICAID PROGRAM.

THE HEALTH CARE FINANCING ADMINISTRATION'S APPROACH IN GRANTING WAIVERS HAS BEEN TO ALLOW THE STATES MAXIMUM FLEXIBILITY IN PLANNING THEIR WAIVER PACKAGES AND IN DEMONSTRATING COST-EFFECTIVENESS AND EFFICIENCY, ACCESS,

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AND PROJECTED PROGRAM IMPACT. WE EVALUATE WAIVER REQUESTS ON A CASE-BY-CASE BASIS, BEARING IN MIND SPECIAL CIRCUMSTANCES THAT MAY APPLY IN EACH STATE.

STATUS OF FREEDOM OF CHOICE WAIVERS

TO DATE, HCFA HAS GRANTED 34 WAIVERS TO 16 STATES UNDER THE FREEDOM OF CHOICE WAIVER PROVISION. (STATES MAY REQUEST MORE THAN ONE WAIVER, THUS THE TOTAL NUMBER OF WAIVERS GRANTED IS GREATER THAN THE NUMBER OF STATES MAKING REQUESTS.) THE MOST FREQUENT REQUEST HAS BEEN FOR WAIVERS FOR CASE MANAGEMENT PURPOSES, WHICH TYPICALLY UTILIZE FAMILY PRACTICE PHYSICIANS, INTERNISTS, PEDIATRICIANS, OR PHYSICIAN EXTENDERS TO PROVIDE PRIMARY CARE, AND PROVIDE FOR OR ARRANGE A FULL SCOPE OF HEALTH CARE INCLUDING SPECIALIZED SERVICES. WE HAVE APPROVED 23 SUCH WAIVERS. WE HAVE APPROVED EIGHT WAIVERS TO RESTRICT CHOICE OF PROVIDERS, AS WELL AS THREE WAIVERS TO SHARE COST SAVINGS WITH STATE MEDICAID BENEFICIARIES, AND ONE WAIVER FOR A LOCALITY TO ACT AS A CENTRAL BROKER.

I WOULD LIKE TO HIGHLIGHT FOR YOU JUST A FEW OF THE INNOVATIONS WHICH HAVE BEEN POSSIBLE UNDER THESE WAIVER PROVISIONS.

UTAH HAS USED THE WAIVER AUTHORITY TO IMPLEMENT A CASE MANAGEMENT SYSTEM, UNDER WHICH MEDICAID BENEFICIARIES ARE REQUIRED TO CHOOSE A PRIMARY CARE PROVIDER. THEY MAY CHOOSE THIS PROVIDER FROM A GROUP OF FEE-FOR-SERVICE PHYSICIANS OR FROM ONE OF TWO HMOS. THESE CASE MANAGERS WILL BE RESPONSIBLE FOR PATIENT CARE AND ALL REFERRALS TO SPECIALISTS, LABS, HOSPITALS, AND PHARMACIES. THE STATE LATER EXPANDED ITS WAIVER EFFORTS TO ALSO IMPLEMENT A SELECTIVE PROVIDER CONTRACTING PROGRAM FOR HOSPITAL SERVICES. IN ADDITION, UTAH HAS USED THE WAIVER AUTHORITY TO CREATE A PREPAID HEALTH PLAN TO PROVIDE COMPREHENSIVE CLINIC SERVICES AND DAY TREATMENT SERVICES TO THE DEVELOPMENTALLY DISABLED AND MENTALLY RETARDED, ADULT MENTALLY ILL, CHILD MENTALLY ILL, FRAIL ELDERLY, ADULT HANDICAPPED, AND CHRONIC SUBSTANCE ABUSERS.

WASHINGTON HAS RESTRICTED PROVIDERS TO IMPLEMENT A PREPAID CAPITATION PLAN TO PAY FOR PRESCRIPTION DRUGS PROVIDED TO RECIPIENTS IN LONG TERM CARE FACILITIES.

CALIFORNIA HAS USED THE WAIVER AUTHORITY TO IMPLEMENT A PROGRAM OF SELECTIVE CONTRACTING WITH 245 HOSPITALS IN THE STATE. THOSE HOSPITALS, WHICH HISTORICALLY ACCOUNTED FOR 88 PERCENT OF TOTAL STATE MEDICAID EXPENDITURES, OFFERED THE MOST COST-EFFECTIVE ARRANGEMENTS FOR INPATIENT HOSPITAL

SERVICES TO THE MEDICAID (MEDI-CAL) POPULATION. CALIFORNIA HAS ALSO BEEN GRANTED A WAIVER FOR A PRIMARY CARE PHYSICIAN CASE MANAGEMENT SYSTEM WHERE THE PHYSICIAN ACTS AS A "GATEKEEPER" FOR ENROLLED BENEFICIARIES. THAT PROGRAM IS IN THE PROCESS OF BEING IMPLEMENTED.

OUR EXPERIENCE WITH IMPLEMENTATION OF THE WAIVER AUTHORITY INDICATES THAT STATES OFTEN REQUIRE MORE TIME THAN THEY ANTICIPATED TO IMPLEMENT THEIR WAIVER PROGRAMS. A NUMBER OF STATES HAVE SUBMITTED WAIVER REQUESTS, AND HAVE SUBSEQUENTLY WITHDRAWN THOSE REQUESTS.

AS REQUIRED BY THE STATUTE, THE SECRETARY WILL BE SUBMITTING TO CONGRESS BY SEPTEMBER 30, 1984 A REPORT ON WAIVERS GRANTED UNDER THIS SECTION. I WOULD LIKE TO NOTE THAT, RECOGNIZING CONGRESSIONAL INTEREST IN THIS PROGRAM, WE DO PROVIDE MONTHLY REPORTS TO COMMITTEE STAFF ON AN INFORMAL BASIS.

MONITORING

THE HEALTH CARE FINANCING ADMINISTRATION IS MONITORING THESE WAIVERS IN A NUMBER OF WAYS. THE REGIONAL OFFICES ARE RESPONSIBLE FOR REVIEWING THE WAIVERS THROUGH THE ANNUAL STATE ASSESSMENT PROCESS. TO FACILITATE THAT WORK WE HAVE

PROVIDED A SPECIAL REVIEW GUIDE SECTION ON THE WAIVER PROVISION, FOCUSING PARTICULARLY ON THE FREEDOM OF CHOICE AND THE HOME AND COMMUNITY-BASED CARE WAIVERS. IN ADDITION, CENTRAL OFFICE STAFF HAVE PERFORMED A NUMBER OF ON-SITE ASSESSMENTS IN STATES WITH WAIVER PROGRAMS.

EVALUATION

AS I NOTED EARLIER, THE STATES ARE REQUIRED TO DOCUMENT THE RESULTS OF THEIR WAIVER EFFORTS. IN ADDITION, HCFA IS FUNDING AN OVERALL EVALUATION OF THE WAIVER PROGRAMS. WE HAVE CONTRACTED WITH JAMES BELL AND ASSOCIATES, SYRACUSE UNIVERSITY, THE NATIONAL GOVERNORS' ASSOCIATION, AND THE URBAN INSTITUTE TO EVALUATE A NUMBER OF ISSUES RELATED TO FREEDOM OF CHOICE WAIVERS, NONWAIVER PROVISIONS RELATED TO FREEDOM OF CHOICE, THE IMPACT OF CHANGES ON HEALTH CARE COSTS AND UTILIZATION, AND CONSEQUENCES OF THE 1982 LIMITATION ON 1903(M) HMO WAIVER AUTHORITY. A PRELIMINARY DESCRIPTIVE REPORT ON WAIVERS AND NONWAIVER CHANGES RELATED TO FREEDOM OF CHOICE IS DUE IN DECEMBER 1984, WITH A FINAL REPORT DUE IN DECEMBER 1986.

IN ADDITION TO THE OVERALL EVALUATION, HCFA WILL ALSO BE FUNDING SEVERAL INDIVIDUAL STATE EVALUATION EFFORTS. WE HAVE ALREADY ISSUED ONE EVALUATION GRANT TO MICHIGAN, AND WE

MAY AWARD SEVERAL OTHERS IN THE NEAR FUTURE. ALL OF THESE EVALUATION EFFORTS ARE STILL IN THE PRELIMINARY STAGES.

WE BELIEVE THAT ANY CONCLUSIONS WITH RESPECT TO HOW WELL THE WAIVER PROGRAMS CAN CONTROL COSTS OR THE EFFECT OF PROVIDING INCENTIVES FOR APPROPRIATE UTILIZATION MAY BE PREMATURE. THE WAIVERS HAVE NOT BEEN IN EFFECT LONG ENOUGH TO PROVIDE DATA REGARDING EFFECTIVENESS. HOWEVER, WE STRONGLY SUPPORT THE FLEXIBILITY PROVIDED TO THE STATES BY THE WAIVER PROVISIONS. WE FEEL THAT THE WAIVERS, PARTICULARLY THOSE FOR CASE MANAGEMENT, WILL ASSURE CONTINUITY OF CARE FOR MEDICAID BENEFICIARIES. THE WAIVERS MAY PROVIDE GREATER ACCESS TO CARE AS WELL.

WE ARE OPTIMISTIC AND ENTHUSIASTIC ABOUT THE EFFORTS THE STATES HAVE UNDERTAKEN TO DATE, AND WE HOPE AND BELIEVE THAT THE EXPERIENCE UNDER THESE WAIVERS MAY PROVIDE INFORMATION CRITICAL TO STATES INTERESTED IN REVITALIZATION OF MEDICAID DELIVERY SYSTEMS.

I WILL BE HAPPY TO ANSWER ANY QUESTIONS YOU MAY HAVE.

Senator DURENBERGER. Let me start first just with a general question that I didn't have time to ask the State people. Would you give me your observations about the impact of budgetary reductions, or reductions in the growth in medicaid funding at the Federal and State levels for facilitating these waiver experiments. And again, I am just asking for a general observation over the last couple of years.

Dr. DAVIS. I think it is very clear, as we have looked at the impact over the last 3 years, that we have seen a significant reduction in overall medicaid outlays. Primarily, I think the first year the States reacted by looking at the issues of perhaps restriction and eligibility—restriction in the number of visits and issues like this. But very quickly, I believe, that they focused on the idea of longer range concerns for restructuring their program, as I heard some of the States mentioning this morning.

And I think that that is clearly the way to go. We have anecdotal evidence that they have been able, for example, to restrict the use of the emergency room services in a number of these States through of case management. Of course, use of emergency rooms results in higher costs when they do care for the patients, and they lack continuity of care. So, I think that perhaps what started as an activity for gaining control of costs actually will prove to be a better methodology for delivery of preventive care services and for continuity of care.

Senator DURENBERGER. It strikes me that the States are always going to have a problem, because they are stuck with those people, in effect.

Dr. DAVIS. Yes.

Senator DURENBERGER. That is not a prejorative characterization, but I mean, they have got a real problem because if it isn't State level financing that is stuck with it, it is city, county, or local government. So, the incentive ought to be at that level to find better ways to do things. And at the Federal level, when we do 2175 and some of these other things, we are trying to help the localities in some fashion. Are there areas that have occurred to you in which we might be more helpful than we have been to date, either legislatively or in an appropriations area or something else. What might we be missing in this area we are calling freedom of choice that we ought to consider?

Dr. DAVIS. I think it is still a little early for us to have a good handle on this, Senator, because, as I indicated earlier, so many of these case management waivers are fairly new. We primarily heard two issues from the States, and I think I heard them both addressed here this morning. One was the requirement in the 1903(m) provision for the 75/25 enrollment split—in other words, the necessity to have 25 percent of the patients in the HMO non-medicaid or medicare beneficiaries—clearly is an issue for selected areas of the country where they find a geographic limitation that contains almost exclusively a medicaid-type population. They have clearly addressed that.

I think a second area has been one that the provider community has been concerned about, namely, the ability of the beneficiary to opt out at any point in time, rather than be locked site it in for say, a 6-month period of time. This means that the providers

cannot plan for the numbers of beneficiaries. Those two seem to be the major issues that have cropped up that I am familiar with at this point, but there may be other ones that we will discover as we do an extensive review in our evaluation process.

Senator DURENBERGER. Again, a general question. I know that you have to go shortly. When you look out over the country, today, what are you seeing States doing? Are you seeing more and more moving in the direction of the waiver approach. Do you see States wanting to use some freedom of choice, or do you see them just cutting back the dollars, or do you see them moving on from the direction that Jack pointed out of setting rates and moving toward rate setting and trying to hold down their costs that way? What does America look like today when you look out there at the Medicaid Program?

Dr. DAVIS. I think that primarily we have found that there is a great deal of interest in restructuring the programs by the use of both the freedom of choice waivers and the home and community based services waivers. Since clearly a half of medicaid's budget is related to the long-term care area, this has been an area that they have been increasingly active in. I think that the redesigning through case management and the use of the freedom of choice waivers have become increasingly popular areas.

And I think, in conjunction with that, some of the States are looking at reassessment of reimbursement through either a DRG-type of approach, such as we have used in medicare for payment to hospitals, or through the construction of a State rate-setting authority. And those types of things seem to vary from State to State, but a great deal of interest has been engendered in the waivers.

Senator DURENBERGER. Where, right now, is OMB holding you up or holding this whole process up?

Dr. DAVIS. In relationship to the particular waivers, I don't believe that there is a holdup in any relationship in these particular programs.

Senator DURENBERGER. So, if there is any problem out there, it is your problem? You are causing a problem in holding up waivers?

Dr. DAVIS. I don't like to be accused of being the source of a problem. I don't think we are holding them up either. We have about 10 waivers that are pending at this point in time. Of those 10, we have had about 6 of them that we had to go back and ask for additional information. Many times, because it is a new process to a State—even though we provide a great deal of regional expertise to help them design and to input into the paper flow and explaining to us the quality of care and access and what they believe will be cost effective—we find that we have to go back and ask for additional information because, within our authority, we do have to guarantee access and the fact that it is cost effective. And that does take us some time, but in noting those 10 that are pending, I would point out that with 6 we have asked for additional information. Three of the other four are renewals, and they are just coming in at this point in time. I think we are being fairly expeditious in our review.

Senator DURENBERGER. OK. Thank you very much. I appreciate your testimony and your comments.

Our next panel is a panel of health care providers and consumers. Sara Sinclair, president of the Utah Health Care Association, in Logan; Steve Press, vice president of the Federal-State Relations, American Health Care Association; Judith G. Waxman, National Health Law Program; and Rina Spence, former project director of the Commonwealth Health Care Corp. in Boston.

OK. We have everybody. We will start with Ms. Sinclair.

STATEMENT OF SARA SINCLAIR, PRESIDENT, UTAH HEALTH CARE ASSOCIATION, LOGAN, UT

Ms. SINCLAIR. Thank you, Mr. Chairman. I am representing the American Health Care Association. The American Health Care Association is the largest organization of nursing home providers. Also, I am the administrator of the Sunshine Terrace Foundation, a nonprofit nursing home provider in Logan, UT, and the chairman of the board of the Utah Health Care Association. Sunshine Terrace is a 172-bed skilled nursing facility and currently the largest one in the State of Utah. Accompanying me is Gary F. Capistrant from the AHCA staff.

AHCA supported the principles behind section 2175 of the 1981 Omnibus Budget Reconciliation Act, and encourages the development of such innovations in the medicaid program but not at the expense of beneficiary access to services and quality of care. As a registered nurse, I am most concerned about these issues.

AHCA would like to express its concern over one type of freedom of choice waiver that, when improperly implemented, could possibly be catastrophic to nursing home patients and long-term care, and that is the competitive bidding system for nursing home residents.

Senator DURENBERGER. Sounds good. Tell me what is wrong with it.

Ms. SINCLAIR. I will tell you. AHCA believes that a competitive bidding system for nursing home residents that is predicated on price alone is both insensitive to patient well being and fiscally inappropriate if medicaid is to maintain reasonable access to quality nursing home care.

Currently, Utah is considering a competitive bidding system under medicaid for long-term-care services. The primary emphasis behind Utah's consideration of competitive bidding is to cut additional dollars from the program. However, the current medicaid reimbursement system in Utah is both efficient and economical. In 1981, the Utah medicaid program adopted the modified flat rate payment system for nursing homes and the Utah Health Care Association suggested this in the beginning and supported it. Nursing home providers under this system over the past 2 years have saved $11 million in the medicaid system.

This is what is wrong with the competitive bidding idea now. The intensity of care level in Utah nursing homes has increased greatly over the past 4 years, as we have seen an increasingly heavier care patient. Yet, we have only a miniscule number of patients classified as needing skilled nursing care in the State. Three years ago, we had 1,179 medicaid nursing home residents classified as skilled care. Today, we have less than 150 patients classified as skilled and

that is solely because of a change in the State's criteria used to define skilled care. Our heavy-care patients are either in hospitals or in intermediate-care beds receiving payment at the medicaid intermediate-care rate. A move to competitive bidding without acknowledging the current trend in Utah toward more intermediate patient classifications and the national trend toward sicker patients in nursing homes—that is, skilled- or heavy-care patients—will be detrimental to the medicaid population. Unless the access problem, particularly for heavy-care patients, and the quality of care issue are dealt with, both the recipients and the providers face serious problems in trying to meet their needs under this system.

We in Utah and the American Health Care Association are concerned that in the movement toward elimination of freedom of choice considerations of ideas like competitive bidding should not be rushed into for cost containment purposes only, without serious consideration of the equally important issues of quality and access to care. In addition, I would like to make a general comment that a public forum should be part of the waiver process. Thank you.

Senator DURENBERGER. Thank you very much.

Ms. Waxman.

[The prepared statement of the American Health Care Association follows:]

Statement By

American Health Care Association

On

Medicaid "Freedom of Choice" Waivers

Before The

Subcommittee on Health
Committee on Finance
U.S. Senate

March 30, 1984

Mr. Chairman and Members of the Subcommittee:

My name is Sara V. Sinclair and I am representing the American Health Care Association. AHCA is the largest organization of nursing home providers, representing 8000 facilities which care for 800,000 patients. Also, I am Administrator of Sunshine Terrace Foundation, a non-profit nursing home provider in Logan, Utah, and am Chairman of the Board of the Utah Health Care Association.

AHCA supported the principles behind Section 2175 of the 1981 Omnibus Budget Reconciliation Act which were to increase the administrative efficiency of the Medicaid program by authorizing the Secretary of Health and Human Services to waive certain program requirements. Section 2175 allows the Secretary to specifically waive the freedom of choice requirements by allowing states to place restrictions on providers from whom an individual may obtain services. This administrative flexibility can lead to greater economies and efficiencies in the administration and operations of the Medicaid program.

AHCA encourages the development of such innovations in the Medicaid program, but not at the expense of beneficiary access to services and quality of care. Freedom of choice waivers should be supported as long as assurances are provided that:

a. providers accept and comply with reimbursement, quality and utilization standards under the state plan,

b. restrictions are consistent with standards of access, quality, and efficient and economic provision of care and services, and

c. restrictions do not discriminate among classes of providers on grounds unrelated to their demonstrated effectiveness and efficiency in providing services.

The AHCA would like to express its concern over one type of freedom of choice waiver that when improperly implemented could be catastrophic to nursing home patients and long term care--a competitive bidding system for nursing home residents.

Competitive bidding arrangements can result in lower costs to the government for care provided to public program beneficiaries. However, AHCA is concerned that this method could also result in a tradeoff of quality care and sufficient access to care--only exacerbating the current difficulties for Medicaid eligible individuals. To be effective, competitive bidding would have to occur among homes for a given standard of care with no adverse impact on access to such care for program beneficiaries.

AHCA believes that a competitive bidding system for nursing home residents, that is predicated on price alone, is both insensitive to patient well-being and fiscally inappropriate if Medicaid is to maintain reasonable access to quality nursing home care. The elderly population is increasing rapidly--the age 85 and over population is projected to double in the next 18 years, for example. The U.S. General Accounting Office has recently documented what nursing homes have known for a long time, that over the past several years patients being admitted to nursing homes are more functionally impaired and have more intensive care needs. In addition, Medicare's new diagnosis-based prospective payment system for inpatient hospital services is already resulting in increased nursing home patient admissions, who require greater care needs and services, as hospitals are encouraged to reduce acute care lengths of stay. These trends indicate nursing homes will have to increase their levels of service intensity in the future in order to provide quality care to a sicker patient population. Public payment systems need to be sensitive to the increasing care needs of nursing home residents, while recognizing that nursing homes are already low cost and efficient health care providers. Consider the fact that at my facility an intermediate care patient who requires <u>total</u> care pays only $1.43 per hour for 24 hour licensed nursing care and services of many other medical and social service professionals. This amounts to $34.37 a day. This is less than the cost of a quality motel room in Logan.

A competitive bidding system under Medicaid freedom of choice waiver authority has been implemented in California, but only for hospital services. While this bidding system has not been fully evaluated, it has raised some concerns in that state over patient access and quality of care for Medicaid recipients because

of its heavy emphasis on cost cutting. In Arizona, a similar type of demonstration for medically indigent patients has been undertaken by the State and the federal governments. The preliminary results of this system indicate massive cost overruns and an administrative nightmare.

Currently, Utah is considering a competitive bidding system under Medicaid for long term care services. The primary emphasis behind Utah's consideration of a competitive bidding system for nursing home care is to cut additional dollars from the program. However, the current Medicaid reimbursement system in Utah is both efficient and economical. In 1981, the Utah Medicaid program adopted a negotiated payment system for nursing homes which the Utah Health Care Association supported. Nursing home providers, under this system, have saved the Medicaid program $11 million over the past 2 years.

The intensity of care level in Utah nursing homes has increased greatly over the past four years as we have seen an increasingly heavier care patient, yet we only have a miniscule number of patients classified as needing skilled nursing facility care in the state. Three years ago, we had 1179 Medicaid nursing home residents classified as needing SNF care. Today, we have less than 150 patients classified under Medicaid as needing SNF care solely because of a change in the state's criteria used to define skilled care. Our heavy care patients are either in hospitals or in intermediate care beds receiving payment at the Medicaid intermediate care rate. A move to competitive bidding without acknowledging the current trend in Utah toward more ICF patient classifications and the national trend toward sicker patients in nursing homes, i.e. SNF/heavy care patients, will be detrimental to the Medicaid population. Unless the access problem, particularly for heavy care patients, and the quality of care issue are dealt with, both the recipients and the providers face serious problems in trying to meet their needs under this system.

In summary, we in Utah, and the American Health Care Association, are concerned that in the movement towards elimination of freedom of choice, consideration of ideas like competitive bidding should not be rushed into for cost containment purposes only, without consideration for the equally important issues of quality and access to care.

STATEMENT OF JUDITH G. WAXMAN, J.D., NATIONAL HEALTH LAW PROGRAM, WASHINGTON, DC

Ms. WAXMAN. My name is Judy Waxman, and I am with the National Health Law Program. We appreciate your invitation to testify this morning on this matter which is of great importance to our clients. The National Health Law Program is a health law support center that is funded by the Legal Services Corp. to provide professional advice and assistance to legal services lawyers, and advocates and clients from all over the country. Our testimony this morning is based on our experience in providing that assistance and our extensive knowledge of the medicaid program and in particular the concerns our clients have expressed to us about the subject of today's hearing.

It is basically our position that primary case management systems are a two-edged sword. We do believe that they can, in fact, increase access for our clients, encourage greater use of primary and preventive care, decrease overutilization and inappropriate utilization and increase quality, and reduce program costs. Unfortunately, as painful experience has shown, they can also decrease access to care, result in underutilization of services, lock recipients into poor quality or inappropriate providers, and ultimately increase medicaid costs. We think that there are particularly grave problems that could exist in a capitated system where there are incentives for providers to provide less care and make more money, therefore this is one of the areas that I would like to emphasize this morning. Our concern is that in the rush to establish some of these innovative plans, there may not be careful planning and actual problems that we have seen in some places may be ignored. I was really glad to hear this morning that—Dr. Davis said that in fact some States are pulling back and doing more planning. We think this is a good thing—planning is extremely important.

I would like to quickly go through my testimony which contains some lessons we have learned from, the capitated plans that have been in existence the longest—the Arizona health care cost containment system known as AHCCCS and the Kentucky "Citicare" system. We think it is possible to learn some lessons about how to make these systems work better.

Lesson No. 1. Careful planning is essential for an effective program. States are rushing to implement case management systems, sometimes with little understanding of how complicated they are. One would not expect a $180 million business with 150,000 customers to set up shop in 4 months, but that is exactly what Arizona did when they established the Arizona health care cost containment system. After a year of operation, access is still without a workable system to enroll eligible patients. Thousands of the poor have been lost in the computers and enrollment delays in a mixup lasting several months has resulted in serious harm, and some patients who are eligible for the AHCCCS program, are still unable to obtain care. Similarly, systems to monitor access and quality are often inadequate from the outset.

Lesson No. 2. Extreme caution must be used when choosing private firms to administer the case management system. Both Arizona and Kentucky have been unhappy with the private firms they

chose to administer their systems. Arizona contracted with McAuto Systems Group, Inc., known as MSGI. MSGI's original bid was for $8 million for their 3-year contract, but that was increased to $11.4 million before the contract was even signed, and by the time MSGI was dismissed on March 15, they were telling the State that they would need $35 million to complete their contract. This mishandling of funds caused an economic crisis in the State when the State tried to come up with the money to keep the plan going.

Complaints by citicare physicians in Kentucky on the lack of needed data to monitor their specialty and hospital use and late payments has resulted in intense pressure there, to fire Healthcare America, after only 8 months on the job.

Lesson No. 3. Without a careful monitoring of the access and quality, these systems are likely to result in harmful underutilization and the denial of needed care. The financial incentives exist for providers to give less care in a capitated system, so what is really needed, of course, is utilization controls to prevent underutilization and denial of care, again these were absent when Arizona set up its plan. In fact, the AHCCCS medical director, Dr. Jeffrey Schwimmer, resigned on January 31, 1983—less than 2 months after taking the job—charging that he had received hundreds of complaints about poor, inadequate, and abusive care, complaints which MSGI ignored. Dr. Schwimmer found that some ACCESS doctors refused necessary but expensive care and that in extreme cases, doctors groups had actually attempted to disenroll these high-risk utilizers from the plan.

Quality is also an issue in the Louisville citicare system. Physicians' prior authorization is needed for emergency care, except when care is needed to prevent death or permanent impairment. Sometimes authorization is very difficult to get when primary care providers cannot be contacted and are reluctant to authorize care. We know of several documented cases where people really did need emergency care and didn't get it. The same kind of problems exist when patients are referred to specialists and don't get the specialist care they need. Other access issues such as insuring that patients have proximity to providers has not been adequately addressed, and adequate grievance procedures have not been set up from the start, grievance procedures might, in fact, help alleviate some of the kinds of problems I have outlined.

Lesson No. 4. Capitated case management systems do not necessarily assure reductions in medicaid costs. Estimates are coming in now that the per capita cost for enrollees in AHCCCS are actually 27 percent higher than nationwide medicaid per capita costs.

Senator DURENBERGER. Are you getting near the end of your comments?

Ms. WAXMAN. Yes. Lesson No. 5. Administrators in contracting provider groups can engage in profiteering unless properly monitored. We have lots of examples in my testimony about how the AHCCCS administrators held onto money for long periods of time in order to earn extra interest, and how one of the provider groups in Arizona, Health Care Providers, has used patient's money for contracts with other provider group entities that the owners of Health Care Providers owned.

No. 6—and I only have two more. No. 6 and No. 7. No. 6. Operation of the case management system may cause undesirable policy consequences for other aspects of the health care system. In fact, the county system that AHCCCS was intended to help has been very detrimentally affected by the AHCCCS program and has resulted in the abandonment of other indigents in the county that are not eligible for AHCCCS.

Lesson No. 7—last one. Case management systems must be more carefully monitored by Government to avoid untold consequences. We have heard—Dr. Davis talked about it this morning—about how HHS is monitoring these programs. I would like to add that we think it wouldn't be asking too much of HHS to actually require evidence that enrollment processes will work, that provider participation will in fact be sufficient so that access will not be impaired, that effective quality monitoring and grievance systems are in place, and that access to emergency and special services will not be impaired.

We do not oppose the expanded use of case management systems. What we do oppose is a headlong plunge into them without adequate advance planning and protections, and we hope that the actual evidence we have seen through the plans that exist will be taken into account so that grave harm does not result. Thank you.

Senator DURENBERGER. Thank you very much.

Ms. Spence.

[The prepared statement of the National Health Law Program follows:]

Testimony of

National Health Law Program

Mr. Chairman and members of the Committee

We appreciate Senator Durenburger's invitation to testify today on a matter of great importance to our clients.

The National Health Law Program is a health law support center funded by the Legal Services Corporation to provide professional advice and assistance to legal services advocates and their clients. We have extensive and ongoing contact with poor people and their representatives throughout the country regarding a variety of health subjects, including Medicaid, which are of vital concern to them.

Our testimony is based on our experience in providing professional assistance to clients and our extensive knowledge of the Medicaid program and in particular the concerns our clients have raised with us about the subject of today's hearing, namely, Medicaid primary care case management systems.

Considerable interest has been generated in recent years over expanded use of Primary Care Case Management Systems in the Medicaid program. Under the Omnibus Budget Reconciliation Act of 1981, states were actively encouraged to experiment with them (see §1915 of the Social Security Act, 42 U.S.C. 1396n). These systems are seen by many as an important means of controlling governmental health spending.

A case management system is one in which each recipient selects or is assigned to a "primary care case manager"---a physician, clinic, etc.---who must authorize all medical

care for the recipient. Such systems can operate simply by paying the primary care case manager a fee or bonus to manage recipients' care---in fact the majority of existing case management systems use this format. On the other hand, the systems can rely on capitated payments, where the case manager receives a fixed fee for each recipient and may be at financial risk to provide all necessary services from that payment.

It has long been known that primary care case management systems are a two-edged sword. They can increase access to medical care for recipients, encourage greater use of primary and preventive care, decrease overutilization and inappropriate utilization, increase quality and reduce program costs. Unfortunately---as painful experience has shown---such systems can also decrease access to care, result in underutilization of services, lock recipients into poor quality or inappropriate providers, and, ultimately, increase Medicaid costs. The potential for these latter problems is particularly strong in capitated systems---where providers can make more money by providing less care. Congress has recognized these potential problems in enacting provisions such as §1903(m)(2) of the Social Security Act, 42 U.S.C. 1396b(m)(2) which provides some protections against potential abuses.

Whether these systems will promote health care for the poor or undermine an already shaky Medicaid system is not clear. Certainly the manner in which they are planned,

implemented and monitored will be critical. Reports and comments by many public officials and analysts euphorically tout the positive potential in these systems---particularly those systems employing capitation---without underscoring their negative aspects. The systems are often cheered as the panacea of Medicaid reform and cost-containment, without acknowledging that they can open up a pandora's box of problems.

Advocates of these systems often show a remarkable lack of attention to the problems these systems can pose for the needy people they are supposed to help. The pursuit and establishment of the system itself, with the actual problems experienced by recipients are dismissed as growing pains if considered at all. Symbolic of this focus is a recent audit letter from HCFA officials to representatives of Arizona's problem-racked "AHCCCS" capitated system. The letter congratulates program officials on their work in creating and implementing the system, and only later notes that the system has problems of "eligibility, enrollment and coverage."

Proponents of capitated case management systems look to the experience of Health Maintenance Organizations as evidence of the reform and money-saving potential of their new systems and then propose systems which lack the organizational, staffing and patients rights features of HMO's (and overlook that some HMO's do fail).

The history of California's prepaid health plans in the 1970's and, more recently, Arizona's AHCCCS program and Louisville's "Citicare" system can and should teach us lessons on how to make these systems work. If we fail to adequately learn these lessons, then we will not only have lost our chance to provide better care for this nation's neediest citizens but we will have seriously harmed countless thousands.

LESSON #1: Careful planning is essential for an effective program.

States are rushing to implement case management systems with little understanding of how complicated they are. One would not expect a $180 million business with 150,000 customers to set up shop in four months but that is exactly what Arizona did in establishing the Arizona Health Care Cost Containment System known as AHCCCS.

Sophisticated computer systems are needed to adequately enroll recipients and monitor the care they receive. The enrollment process for many case management systems depends on adequately merging three different enrollment data sources: federal SSI tapes; state AFDC tapes; and County Medically Needy information. Yet after a year of operation, AHCCS is still without a workable system to enroll eligible patients. Thousands of poor have been "lost" in the computers and enrollment delays and mix-ups lasting several months have resulted

in serious harm and death to patients eligible for AHCCCS but unable to obtain care.

NHeLP is unaware of any Medicaid case management system, regardless of how well planned, which has not had some enrollment difficulties. Indeed, administrators of the Monterey Health Initiative, in California will be the first to admit of troublesome enrollment problems, despite a three year planning process.

Similarly, systems to monitor access and quality are inadequate. Freedom of Choice waivers to restrict recipients to certain providers are predicated on state promises to ensure access and quality. Yet too often case management systems have no mechanism in place to determine the amount and kinds of services provided enrollees.

LESSON #2: Extreme caution must be used when choosing private firms to administer their case management systems.

Both Arizona and Kentucky have been unhappy with the private firms they chose to administer their systems. Arizona contracted with McAuto Systems Group Inc. (MSGI) although Blue Cross bid $1 million less for the contract. MSGI's original bid of $8 million was increased to $11.4 million before the contract was signed. When MSGI was dismissed on March 15, estimates were set that the administrative costs would reach $35 million, triple the base price. One audit found that the firm overcharged the state more than $544,000 during the first three months of the program's operation.

MSGI was chosen because of its "expertise and hands on experience in establishing experimental prepaid health systems," despite its questionable history. MSGI's forerunner, Bradford Administrative Services Inc. had been a subsidiary of Bradford National Corporation which, in December 1981, pleaded guilty to twenty counts of defrauding the federal government of $750,000 in fraudulent billing records.

Nor is the Citicare program in Kentucky happy with its choice of Healthcare America to administer its case management system. Complaints by Citicare physicians on the lack of needed data to monitor their specialty and hospital use and late payments has resulted in intense pressure on the state to fire Healthcare America after only eight months on the job.

LESSON #3: Without a careful monitoring of access and quality, these systems are likely to result in harmful underutilization and the denial of needed care.

In the fee-for-service system, the obvious incentive is for physicians and hospitals to provide excessive care; the more care provided, the more money made. In a capitated case management system the exact opposite incentive exists; the less care provided, the more money left over for the provider. Utilization controls are needed in a fee-for-service system to prevent overutilization and the provision of unneeded care; in a case management system, utilization controls are needed to prevent underutilization and the denial of needed care.

Such controls were absent when California instituted its Prepaid Health Plans (PHP) system in the 1970s. Clinics which promised to be open 24 hours a day, seven days a week were actually open only a few hours a day; plan enrollees were told to go to hospitals for emergency care which had never heard of the plan; and needed specialty care was often not available. Yet, the state did little to monitor PHPs when scandal rocked the system.

The only large-scale Medicaid case management system since California's, Arizona's AHCCCS program, has been similarly negligent. AHCCCS's Medical Director, Dr. Jeffrey Schwimmer, resigned on Jan. 31, 1983 less than two months after taking the job, charging that he had received hundreds of complaints about poor, inadequate and abusive care, complaints which MSGI ignored. Dr. Schwimmer found that some AHCCCS doctors refused necessary but expensive care and that, "in extreme cases, plans (doctor groups) have actually attempted to disenroll these high-risk utilizers from the plan."

In a taped January conversation made public by the Arizona Republic one of the owners of Health Care Providers of Arizona, a group which has contacts with AHCCCS, was recorded as saying, "We have to come up with a system where we have a right to override doctor's decisions."

Quality is also an issue in Louisville's Citicare capitated system. Physician prior authorization is needed for all emergency

care except care needed to prevent death or permanent impairment. This authorization is often difficult to obtain as several primary care physicians are not easily contacted and have been relunctant to authorize care. In several documented instances, Citicare patients were denied needed emergency care. In one such case, a woman denied emergency care was hospitalized two days later for a painful pelvic infection.

Problems have also occurred in Citicare when physicians refuse to refer their patients to specialists. Like Arizona's AHCCCS program, Citicare does not appear to have any quality controls.

Even basic access issues such as insuring that patients enrolled in capitated systems are no more than twenty minutes away from primary care are not addressed. Citicare, for example, has no contracts with physicians in twelve of thirty-two zip codes in Jefferson County, the area covered by the program.

In Arizona, AHCCCS enrollment has not guaranteed care for some enrollees who were assigned to doctors so far from their homes that they cannot reach them.

Patients enrolled in capitated case management systems with access or quality complaints are often blocked from voicing those complaints due to inadequate and complicated grievance procedures. States with real concerns that Medicaid

patients receive needed care must establish, as part of their monitoring system, mechanisms to ensure that complaints are heard and investigated.

LESSON #4: Capitated case management systems do not automatically assure reductions in Medicaid costs.

Case management systems do not guarantee Medicaid savings. Estimates are that per capita costs for enrollees in AHCCCS are 27% higher than nationwide Medicaid per capita costs.

In Monterey, the County is at risk for cost overruns, as it receives a capitated rate from the state per Medicaid enrollee. While the Monterey plan appears to have reduced emergency room and hospital utilization through increased access to primary care physicians, it has lost money on nursing home care as the capitated rate received from the state for SNF is approximately $500 dollars a month below what the county has to pay for this service. More careful cost calculations would have avoided this problem.

LESSON #5: Administrators and contracting provider groups can engage in profiteering unless properly monitored.

States and localities do not adequately monitor the money made by contracting groups or put a cap on profits. In the AHCCCS program, the amount of profits and whether they come at the expense of patient care is not known. What is known is that the administrator was able to hold on to large sums of money for long periods of time before paying the provider groups and the provider groups held on to large sums of money

for weeks before paying the physicians, hospitals and pharmacies. This resulted in large interest payments being paid to the administrator and the contracting provider groups during the delays.

Arizona contracted with Health Care Providers of Arizona, despite the fact that Medicare previously found them to be performing unnecessary surgery. The March 22 edition of the Arizona Republic reported on an audit of the company's practices involving the AHCCCS project. The audit found that less than half of the $8 million in capitated payments received by the corporation went to patient care. Of the money distributed to providers 13% paid for drugs and half of that (about $280,000) went to a drug company owned in part by two owners of Health Care Providers. Another $290,000 went to two other provider entities owned exclusively by the same two owners of Health Care Providers. Another $770,000 had been distributed to the three owners of the corporation in October and November of 1983 with no explanation noted in the financial records.

Citicare is a Health Insuring Organization (HIO) which by law must assume an underwriting risk. Yet that risk is limited in the program to 1%, hardly momentous, and even that small risk seems to disappear the second year of the program's operations. We do not know if Citicare, its administrator or contracting providers are making excessive profits but

believe the state should have available sufficient evidence to assure this is not the case.

LESSON #6: Operation of a case management system may cause undesireable policy consequences for other aspects of the health care system.

In Arizona, exclusive reliance on low bids to determine which providers could serve particular eligibility groups resulted in the Maricopa County (Phoenix) health system losing about 15,000 of its AHCCCS patients in the program's second year. As the provider of last resort in the Phoenix area, the County services many patients who are uninsured, severely ill and/or have special needs; as a result the County system has above average costs and has difficulty in price competition with providers who do not have such obligations.

The excluded groups had relied on the County system as their regular source of care, and County facilities provided the services most accessible to them. These people suffered severe disruptions in care patterns. At the same time, the County announced it would have to lay off hundreds of employees at its hospital, reducing the staff there by about 25%. Area doctors protested that the constriction of services would result in the "abandonment" of 80,000 indigents in the County.

While the threatened destruction of a County system would be an unintended, shocking result anywhere, it is particularly ironic in Arizona--where adoption of "AHCCCS" was in large part designed to relieve County health services burdens. In

hindsight, the potential for such an occurrence should have been recognized and planned for, but it was not. The rush to implement capitated case management systems will surely result in other harmful and preventable consequences.

Another major problem waiting to happen is the encouragement of nursing home use, at a time when much public policy is encouraging greater use of home health services as an alternative to nursing home care. Most existing case management systems, and apparently most of the pending proposals, do not include long term care. As a result, there is a financial incentive for providers to place people in nursing homes when the patients have chronic or multiple care needs, rather than incur liability for the care themselves.

Another potential problem involves the interplay between a case management system and other special programs. What will happen, for example, when children in a Crippled Childrens Service program have a recommended course of treatment with which their case management provider will not comply. These and other policy consequences of case management systems are beginning to surface now and should be assessed and planned for in advance.

LESSON #7: Case management systems must be more carefully monitored by government to avoid untoward consequences.

Many case management programs result in the limitation of recipients' long-standing free choice of providers. While free choice may have been limited or illusory for many in the past, the new systems can prevent all recipients from remedying any enrollment, access and quality of care problems by seeking care elsewhere. They can break-up existing care patterns and place care of the needy in the hands of people motivated primarily by profit.

Surely in recognition of the potential danger of these systems, Congress has permitted them only by waivers obtainable from the Secretary of Health and Human Services. Until 1981 these programs were recognized as purely experimental, and some systems continue to be authorized only as experiments. The Omnibus Budget Reconciliation Act of 1981, however, gave states greater freedom to establish case management systems. Congress did require the Department of Health and Human Services to monitor these programs and insisted that they not restrict emergency services, and that they not substantially impair access to services of adequate quality where medically necessary.

As we have noted throughout this testimony, assessment and prevention of problems requires substantial efforts in both the planning and implementation of case management systems.

It is scarcely asking too much to require evidence that enrollment processes will work, that provider participation will in fact be sufficient so that access will not be impaired, that effective quality monitoring and grievance systems are in place, and that access to emergency and specialist services will not be impaired.

The Department of Health and Human Services' efforts in this respect must be dramatically improved. While some experimental programs---such as those in California's Santa Barbara and Monterey Counties---engaged in several years' extensive planning before going into operation, the Department of Health and Human Services has appeared equally willing to approve systems where answers to important questions were little more than promises. Many of the problems referred to in this testimony could have been avoided if better advance planning had been required and reviewed.

The Department has encouraged speedy implementation of case management systems. In fact, when Congress amended §1915 in 1982 to limit the extent to which non-HMO's could rely on capitation payments, the Department promptly approved Louisville's "Citicare" capitation system as a "Health Insuring Organization"---something Citicare had not even proposed. If the federal agency encourages speedy implementation over sound planning, states can hardly be expected to do otherwise.

Once a system has been implemented---albeit with built-in problems waiting to happen---there is tremendous inertia in favor of its continuation. Nonetheless, careful monitoring remains vital---unfortunately it is in need of great improvement. Arizona's AHCCCS system has existed for much of its two years without a full time Medical Director. Both in Arizona and Louisville, some critical reports vital to monitoring utilization and costs have never been made. Both the state and the Department of Health and Human Services are hard pressed to even assess the magnitude of patient abuses, which press accounts and individual client stories have noted.

Both the Department of Health and Human Services and the states must more effectively monitor these systems, but the lead belongs where Congress has placed it---with the Department of Health and Human Services

Conclusion

Advocates of case management systems claim that the problems encountered by California in the early 70's and Arizona in the early 80's will not plague their systems. Yet, Arizona learned little or nothing from California's PHP fiasco. And other states appear willing to adopt Medicaid primary care case management systems without carefully looking at how to avoid the abuses so prevalent in the first year of AHCCCS.

We do not oppose the expanded use of case management systems. What we do oppose is the headlong and precipitous plunge into them, without adequate advance planning and protections. Hopes and dreams aside, we urge that the weight of actual evidence be given appropriate attention, evidence which shows that these systems can cause grave harm if they are not carefully planned, implemented and monitored.

STATEMENT OF RINA K. SPENCE, FORMER PROJECT DIRECTOR, COMMONWEALTH HEALTH CARE CORP., BOSTON, MA

Ms. SPENCE. I am Rina Spence, the former executive director of the program whose design was predicated in part on this waiver and whose final failure was attributed to concerns that it raised. Commonwealth Health Care Corp. was a coalition of Boston's teaching hospitals and neighborhood health centers, committed to developing a rational system of care for the poor that would temper the rise in cost to Government. It was formed in 1981 to deal first with AFDC in Boston in response to the State administration threatening reductions in medicaid. In covering all the optional programs of medicaid services in Massachusetts, there existed little incentive for either provider or recipient to change behavior. As a solution, CHCC proposed the development of a prepaid managed care system that would encompass all the city's providers and AFDC recipients. In order to restrict the open-ended fee for services system, Massachusetts applied for a limit on freedom of choice. Cost savings were to be achieved by enrolling recipients into managed care programs with a primary care physician at risk and redirecting some primary care to more cost-effective neighborhood health center sites. The election of a new Governor coincided with the granting of the waiver. The fact that the administration promised no cuts in the medicaid budget began to raise fears on the part of the recipients that the CHCC program was too provider oriented. The freedom of choice waiver became the focal point of recipient protests, and in the end the State succumbed. Neither the waiver nor the program was implemented.

Why should a program so rationally structured fall to the rhetoric of freedom of choice? It is a term that conjures up an emotional response but offers little understanding of the issue. Perhaps to the recipients who organized against CHCC it was the fear of changes in their patterns of receiving care that underlay their concerns This fear, I believe, emerges from a general distrust of institutions, including Government. That the CHCC and the State tried to address freedom of choice as a rational issue—with CHCC pointing to all the choices and the State saying there needed to be more—only shows that both missed the real point—that it was, in fact, a conflict of perceptions.

The large institutions tended to see managed care as efficient and the neighborhood health centers as appropriate sites. The recipients tended to view the proposal as excluding them from unlimited access to the prestigious downtown institutions and directing them into what many erroneously perceived as two classes of care. That freedom of choice is such an issue thus reflects largely a perception of quality by the recipient population. Even so, the two-tiered objection as a result of the proposed limit on freedom of choice lay not as much in the anticipated care but more in the imposition of a system that required trust where it did not sufficiently exist. The issue is not only health centers and hospitals, or managed versus unlimited access, but also allowing oneself—the recipient of care—to trust sufficiently not to feel the need for the seeming protection of existing options and the preservation of the status quo. In the absence of any historical basis for trust, we have

learned that freedom of choice is perceived by the poor as an essential protection against second-rate health care, and the more vocal activitist segment of the poor can mobilize that perception into a significant political force as they did in Massachusetts. Thank you.

Senator DURENBERGER. Thank you.

[The prepared statement Rina K. Spence follows:]

Statement to the Senate Finance Committee

Sub-Committee on Health

30 March 1984

Presented by Rina K. Spence

Formerly, Executive Director

Commonwealth Health Care Corporation

Boston, Massachusetts

Mr. Chairman, members of the sub-committee, thank you for this opportunity to comment on issues related to the Freedom of Choice waiver. I am Rina K. Spence, the former Executive Director of a program whose design was predicated in part on this waiver and whose final failure was attributed to the concerns it raised.

The Commonwealth Health Care Corporation was a coalition of Boston's Teaching Hospitals and Neighborhood Health Centers committed to developing a rational system of care for the poor that would temper the rise in cost to government. It was formed in 1981, to deal first with AFDC in Boston, in response to a State administration threatening reductions in Medicaid. In covering all the optional Medicaid services reimbursed on a fee-for-service basis -- the situation in Massachusetts -- there exists little incentive for either provider or recipient to change behavior. As a solution, CHCC proposed the development of a pre-paid managed care system that would encompass all the city's providers and AFDC recipients. In order to restrict the open-ended fee-for-service option, Massachusetts applied for a waiver to limit Freedom of Choice. Cost savings were to be achieved by 1) enrolling recipients into managed care programs with a primary care physician at risk for specialty referrals and in-patient utilization, and 2) redirecting some primary care to more cost effective Neighborhood Health Center sites. The CHCC proposal received for its development over $1.5 million in private foundation grants.

The election of a new Governor coincided with the granting of the waiver. The fact that the new administration promised no cuts in the Medicaid budget began to raise fears on the part of recipients that the CHCC program was too provider-oriented. The Freedom of Choice waiver became the focal point of recipient protests, and in the end the State succumbed. Neither the waiver nor the program was implemented.

Why should a program so rationally structured fall to the rhetoric of Freedom of Choice? It is a term that conjures up an emotional response but offers little understanding of the issue. Perhaps to the recipients who organized against CHCC, it was the fear of changes in their patterns of receiving care that underlay their concerns. This fear emerges from a general distrust of institutions, including government. That the CHCC and the State tried to address Freedom of Choice as a rational issue (with CHCC pointing to all the choices and the State saying there needed to be other choices) only shows that both missed the real point -- a conflict of perceptions. The large institutions tended to see managed care as efficient and the neighborhood Health Centers as appropriate sites. The recipients tended to view the proposal as excluding them from unlimited access to the prestigious downtown institutions and directing them into what many erroneously perceived as two classes of care. That Freedom of Choice is such an issue thus reflects largely a perception of quality by the recipient population. Even so, the "two-tierd" objection as a result of the proposed limit on Freedom of Choice lay not as much in the anticipated care but more in the imposition of a system that required trust where it did not sufficiently exist. The issue is not only Health Centers and Hospitals, or managed vs. unlimited access, but also allowing one's self -- the recipient of care -- to trust sufficiently not to feel the need for the seeming protection of existing options and the preservation of the status quo.

In the absence of any historical basis for trust, we learned that Freedom of Choice is perceived by the poor as an essential protection against second rate health care, and the more vocal, activist segment of the poor can moblize that perception into a significant political force, as they did in Massachusetts.

Thank you for the opportunity of presenting these observations.

Senator DURENBERGER. What is your advice?

Ms. SPENCE. Excuse me?

Senator DURENBERGER. You can't leave me with "don't trust government." [Laughter.]

Ms. SPENCE. OK. I did try and think of what does one do after this, and I think that, in fact, in Massachusetts it was the situation of our having all the optional programs, and I guess if I were to suggest to other States, I am not sure that I would recommend going after a waiver on freedom of choice if there are other ways—that is, within the program itself—to create those options. I think the fact that, in Massachusetts, we have had no way to offer a little more in the managed care system created a problem. I think in State where the benefit package can be more directed toward prepaid systems and then recipients can choose those plans, I think that would be more advantageous.

Senator DURENBERGER. Ms. Waxman, I heard a lot of your testimony directed at the issue of quality, and it strikes me that if you take your time to do it right you can achieve quality. The thing we struggle with here is the incentives going every which way. You ought to be able to find a situation in which you don't have to artificially create quality measurements. It seems that quality will already exist in a relationship between patient and his or her provider. But I can also recognize that starting a process like you describe, particularly when it is aimed at a population which is categorized by our society in the way that they have their needs met. Do you have some specific suggestions or advice to us on how to assure quality, and I mean getting down to real specifics, not just your seventh point. One of them strikes me—and I think I saw this in Jack Meyer's testimony—that we be sure and take some time in counseling people as to how to get into the system. And from what I know of the situation in Arizona, in regard to the mistakes they made—besides their choice of a contractor, I think this was one of their problems. They never had a medicaid program, and all of a sudden they were going to have one, and they were going to get it done in about 8 months or some incredible period of time. They tried to jam all of that activity into a really short period of time. And I would guess that one of the things they missed out on in that process is just dealing with individual people and helping them through the process of making choices. Are there some specifics in that area of quality that we might be looking at?

Ms. WAXMAN. Sure. I do think the counseling is important, not only on how to get people in and how to use the program but also on how to help that individual get the provider that maybe he or she has already used before. That has been some of the resentment on the part of the recipients—that the old providers they used may, in fact, be in the program, but because of administrative hassles they don't seem to get assigned to that person. If there is a way to counsel people not only into the program, but to their proper providers, that would be helpful.

There also should be counseling on the side of getting providers into the program to be sure that, in fact, there are enough providers in all the geographic and specialty areas so that the individuals have proximity to providers, and that there, are in fact adequate providers in the program to serve the population.

Another point, I would like to make relates to that 1903(m) issue I heard earlier today. I didn't put that in my testimony, but I think keeping the protections that are already in the statute is really crucial for quality. It is sort of sad to say, but if you have a program that is supposedly for poor people, chances are it is going to be a poor program—it is sort of the old adage—raising the old song, if you will, but I think it still holds true.

And when you have the 75/25 percent case mix protection, which in fact was changed recently from 50/50 percent, then at least you are going to assure that there is a mix of people in the plan with different concerns that can address various problems that arise. If you are going to eliminate everyone who is not a medicaid recipient and allow States to make their plans mandatory for medicaid recipients—also another suggestion from this morning—you are setting up a somewhat explosive situation. The law already allows for States to guarantee a minimum 6-month enrollment as an incentive to recipients to enroll in an HMO. As Ms. Spence indicated such positive incentives encourage recipients to make such a choice and then to agree to be enrolled in the HMO for a finite period of time. A guaranteed 6-month minimum enrollment allows the State to know how many people are going to be enrolled and to deal with those other administrative problems they mentioned earlier—without mandating enrollment in a program exclusively for poor people which is really asking for trouble.

Senator DURENBERGER. It strikes me that the ideal is for poor people to be treated like people, and to go into a plan that is available to everybody. And that is the way the experiments up in the Twin Cities are working. You have an HMO card, you don't have a poor person card when you walk in.

Ms. WAXMAN. Exactly.

Senator DURENBERGER. They don't know how you got there or who is going to pay the bill, and that strikes me as being our ideal, and that is why I get a little revved up when I pick on the fellow from Detroit because it upsets me that we waste $6,000 those auto workers—and I say we waste it on them because we are paying for it out of our taxes. And then we don't have enough resources left over to take care of all the truly needy in our society.

Those people don't need that $6,000 a year worth of health care. Maybe a few of them do, but most of them don't. That is a huge waste of resources. And yet, we always have these linkages between the unions and the poor trying to save America. It is just one frustrating example of where, part of the union movement is destroying the health care for the poor in this country by not encouraging more choice of health plans in some of these communities. Do you, Ms. Waxman, have any doubt about the fact that if we had genuine competition, among health care providers in this country, that the people with one of the best quality systems in the world would overcome the failures of the health care system, and wouldn't that be the best way to provide for the needs of people in this country?

Ms. WAXMAN. I have to say I am really not sure of that. I am concerned about poor people because if they don't have resources to get into the competitive system, that they may, in fact, be left out, and so even with a purely competitive system, you are going to

have to have some way to deal with those people who don't have a way to get into it. Jack Meyer said this morning, currently almost half of the people who live below the poverty line are not even on the medicaid program. The studies and figures that are coming out now about how many people in this country are uninsured are just really staggering. There has to be some kind of system, and I don't know what the ideal system is, but some way to take care of that enormous part of our population.

Senator DURENBERGER. Yes; and what we have talked about this morning is taking our medicaid dollars and reimbursing a set of providers or going on a DRG system. What we haven't talked about is moving the way medicare is moving—which is to vouchers. So that each of those people, once the eligibility is determined, is equipped with a voucher, and at that point, you have gone a long way towards equalizing at least financial access.

Ms. WAXMAN. Yes. I think the effectiveness of a voucher system would also depend on how much that voucher was worth to the individual and whether that lower income person with the voucher really was in a competitive situation with higher income people.

Senator DURENBERGER. And that is why we are going slow with vouchers for medicaid. If there is no competition, the voucher is no good. It isn't going to achieve a thing. Now, that gets me to the surplus situation. You know, if you need to have a surplus to achieve competition, and only when you have competition do you have people come in and say—like you have said—don't let them set the price. Now, am I being unfair? It seems to me that AHCA has a position in support of prospective payment in medicare.

Ms. SINCLAIR. That is right.

Senator DURENBERGER. And it seems to me prospective payment addresses price only—sets the price for a service. So, why is it that the position that AHCA has with regard to prospective payment—why in light of that do you take the position that you are against competitive bidding?

Ms. SINCLAIR. Because I believe some providers who are now medicaid providers—medicaid approved providers—would be eliminated from that system at various points in time. That is one reason.

Senator DURENBERGER. Why?

Ms. SINCLAIR. Because if their bid isn't appropriate, they will not receive patients.

Senator DURENBERGER. But somebody will receive patients. Ms. Sinclair. Somebody will—the lowest cost facility will.

Are you implying that——

Ms. SINCLAIR. I am saying that if they meet minimum standards and have the lowest bid, they will receive the patient.

Senator DURENBERGER. Is there anything wrong with that?

Ms. SINCLAIR. I think there is in that what I would like to do is have you put yourself in the place of the son of a person who needs to be on medicaid in a nursing home. Wouldn't you prefer to have a choice of facility for your mother?

Senator DURENBERGER. Yes, but if it is at someone else's expense and it costs me *x* number of dollars to make a choice that was more expensive, then I would be willing to pay that. But if I am not willing to make a payment to exercise that extra choice, then I

should be assured by the local society that I am getting quality service, then I have no problem with my mother going to a low priced facility as long as it has met the quality standards that I want for my mother. It may not be one that I would choose, but if I won't contribute to my choice, then what is wrong with that?

Ms. SINCLAIR. The quality standards is another concern. I had a comment to make on your asking Ms. Waxman about that. Currently, quality in a nursing home—I will speak just to that because that is where I have my expertise—is judged on procedural requirements being met a lot of the time. It is not judged on the outcome of the efforts of the health care team.

Senator DURENBERGER. But that is what you are going to negotiate with your colleague in the back of the room.

Ms. SINCLAIR. That is true, but that is not being done currently, and that is one of our concerns. How is the quality going to be measured in a competitive bidding situation?

Senator DURENBERGER. Gary, do you want to add a concluding statement?

Mr. CAPISTRANT. Yes; you, of course, understand that we do support prospective payments. We even support the concept of competitive bidding. The problem comes in in the exercise of that concept. I think it is a situation in which you can probably develop a competitive bid arrangement that would make sense for nursing homes. What we have seen of the Utah program doesn't do that. You can deal in competitive bids for a standardized product and if there are performance standards for the providers to meet. What we have seen of the Utah situation does not do that, and it exemplifies what you have in section 2175 is very broad authority to the States that can be exercised quite well, but it can also be misapplied. And we would not be recommending at this time any statutory changes to section 2175, but we would be recommending caution and that all of the provisions not be applied for each and every service.

I think that the intent of section 2175 really didn't go to long-term care here. The committee's Blue Book, in its 20 pages, does not even address the long-term care issues. Yes, it is productive to use freedom of choice waivers for HMO's and case management, but there are some real problems in going greatly beyond such uses that I do not think have been sensitively responded to yet.

And so we will continue to work to perspective in medicare and better medicaid systems, but what they are looking at in Utah is not it.

Senator DURENBERGER. Thank you all very much for your testimony. I appreciate it a great deal. The hearing is adjourned.

[Whereupon, at 10:55 a.m., the hearing was concluded.]

[By direction of the chairman, the following communications were made a part of the hearing record:]

Prepared Statement of Robert C. Osborne, Deputy Commissioner for Medical Assistance, New York State Department of Social Services, Albany, N.Y.

Medicaid has become one of the largest and most complex programs which are administered by the States. While no single program has contributed more positively toward closing the gaps in access to, and use of, health services previously experienced by lower and higher income populations, there are still large numbers of Medicaid beneficiaries who have no real access to stable, continuing relationships with health care providers or to comprehensive, consistent and appropriate care. While Medicaid is an enormous part of the way health care is financed in this country, and has assumed a prominent role in driving the health care industry, the current system is becoming an economic dinosaur which depends on an obsolete fee-for-service payment and discourages preventive care.

Faced with increasing fiscal pressures, New York, like other States, has been compelled to explore a variety of methods to control costs. Over the years, New York has met the challenge of minimizing cost increases in the Medicaid program and has done so without reducing the availability of services. However, there are concerns that additional cost control related to reimbursement and program management will continue to be successful in the future. New alternatives to the traditional and often inefficient fee-for-service system are necessary. The enactment of the 1981 Omnibus Budget Reconciliation Act (OBRA) containing the so-called "flexibility provisions" was a two-edged sword. New York State has been understandably conservative in its use. In fact, some of the provisions in Section 2175 of OBRA were already permissable under the Social Security Act.

RECIPIENT RESTRICTION PROGRAM

New York has had a "lock-in" program in place since 1978. The recipient restriction program began on a pilot basis, and was implemented Statewide in 1980. The authority for such a program is contained in Section 1902(a)(30) of the Social Security Act, requiring States to "safeguard against unnecessary utilization of...care and services..." Exception criteria have been developed to facilitate the identification of recipients' overutilization of services through the use of the Surveillance and Utilization Review Subsystem (SURS) of the Medicaid Management Information System (MMIS).

Parameters and criteria are set quarterly and records of claims for a selected period are run against these parameters. The exception reports are reviewed and selected recipients are identified for further review (about 500 a month). Information is compiled on each of the identified recipients concerning utilization of services over the preceding twelve months, the most frequent diagnostic groupings, a pharmacological summary, and most frequently used providers. The package is reviewed by a licensed pharmacist, registered nurse and consulting physician. If a recommendation is made that the recipient be restricted, the case is referred to the local Social Services District.

The District notifies the recipient and offers the opportunity for a conference. The recipient is usually restricted to one of the providers most frequently used by him or her. The provider is contacted to assure his or her willingness to serve as the recipient's primary source of care, and the recipient's Medicaid card is marked to indicate that only bills from the primary provider will be honored. Restriction is limited to an initial period of fifteen months and the case is then reviewed to determine if restriction should continue. There are currently about 1500 restricted recipients with a total restricted population over the life of the program of 7500. Estimated savings are approximately $1500 per restricted recipient per year.

PROVIDER SANCTIONS

New York's provider "lock-out" policy also preceded the enactment of OBRA. State statutory authority for termination, suspension or censure of Medicaid providers was enacted in 1975 and was also implemented under the utilization control provisions in Section 1902 of the Social Security Act. Audit and investigational activities were centralized in one organizational component of the State Department of Social Services in 1976. The staff includes investigators, auditors, lawyers, technical data processing personnel, pharmacists, nurses and three physicians detailed from the State Department of Health for professional review. Providers furnishing excessive or substandard quality services are identified through SURS Subsystem reports on health care delivery and utilization, and Summary System reports on individual provider billing and service practices. Other sources of information are recipient responses to "Explanation of Medical Benefits" issuances and public complaints alleging abuse.

Sanctions imposed by Medicare and by the State Health Department are also channelled through this Fraud and Abuse Unit and providers have rights to administrative hearings and judicial review. Providers who have been suspended or disqualified from the Medicaid program may apply for reinstatement; however, the application may be denied by the Division of Medical Assistance if the provider's past conduct is deemed severe enough to prohibit re-enrollment. Other sanctions may originate with the Education Department, through the Board of Regents, which is empowered to take action against any professional it licenses. Such action also impacts on a provider's participation in the Medicaid program. Last year, 67 providers were suspended from participation in the Medicaid program, 49 of them permanently.

HMO LOCK-IN

New York requested and received a waiver of 1903(m) to require Medicaid recipients who voluntarily enroll in federally qualified HMO's to remain for a minimum enrollment period of five months after the first thirty days of enrollment. This procedure was permitted under the Social Security Act prior to enactment of Public Law 97-35 (OBRA), and was used in all of New York State's HMO/Medicaid contracts. The enactment of the 1982 Tax Equity and Fiscal Responsibility Act (TEFRA) rescinded the authority of the Secretary to grant such waivers.

While New York does not currently have many Medicaid HMO contracts, the State is embarking on an effort to develop and expand HMO's and other types of prepaid plans, and encourages their use by Medicaid recipients. In a Medicaid program like New York's, where virtually every optional service is included, it is difficult to provide incentives in the form of services to recipients to enroll in HMO's. A minimum enrollment period provides an opportunity for the HMO to demonstrate the benefits of continuity of care, and for the Medicaid enrollee to become familiar with the HMO and its services. During the minimum enrollment period, the HMO can provide health education and both preventive and primary care services, as appropriate.

Without the opportunity for the HMO to develop this provider/patient relationship, the care delivered by the HMO would differ little from that provided by the more traditional, often episodic and fragmented fee-for-service system. An individual who is accustomed to the freedom to use (and misuse) the existing fee-for-service system may feel constrained when first limited to a specific provider, and a Medicaid enrollee may feel no different. Accordingly, the HMO requires time to "make its case" and establish itself as a provider of high quality and accessible health care. In the general population, this is accomplished by requiring a minimum enrollment period, usually one year, in which the enrollee becomes familiar with the services provided by the HMO. The lock-in accomplishes the same for the Medicaid population enrolled in HMO's, providing for a minimum enrollment period while simultaneously allowing a recipient to disenroll with good cause.

A mandatory minimum enrollment period also enhances the attractiveness of Medicaid contracting for HMO's. For a variety of reasons, the initial thrust of HMO marketing to the Medicaid population is more time consuming and complex than marketing activities aimed at the general population. The higher marketing costs tend to reduce HMO interest in enrolling Medicaid clients, and may also reduce the potential savings which may be achieved by the HMO. The turnover of Medicaid enrollees due to losses in eligibility is both administratively burdensome and expensive for the HMO. The lock-in of Medicaid enrollees helps reduce enrollee turnover and compensates for those enrollees who are terminated due to losses in eligibility.

ADDITIONAL WAIVER APPLICATIONS

New York State has asked for two additional waivers under the authority of 2175. One is to resolve a long-standing compliance issue concerning Statewideness. Psychological services are an optional service which the State makes available to Medicaid recipients who need them. In New York City, however, a local variance is desired to limit psychological services to those delivered in organized mental health clinics certified under Article 31 of the Mental Hygiene Law where there is assurance of medical supervision and consultation, and a utilization review mechanism approved by the standard-setting agency. Because the network of certified mental health agencies is not as well developed in some upstate counties, and because clinic services are not accessible to recipients who are in residential health facilities Statewide, the State intends to continue to allow the provision of services by private practicing psychologists in certain instances. HCFA's decision on this application is still pending.

The second application also targets medical services in New York City, and the purpose of the waiver is to reduce the rate of expenditure growth for transportation in the City, specifically ambulette services. Under the waiver, the City's Human Resource Administration (HRA) will request the sixty New York City medical facilities with large volumes of Medicaid patients using ambulette transportation, to seek competitive bids and enter into formal agreements with the ambulette company offering the lowest reasonable rate. The waiver would also permit extension of the bidding process to livery services (curb-to-curb services for clients with disabilities precluding the use of public transportation, but who do not require the assistance of ambulette attendants). HRA will reimburse facilities for the administration of the program and monitor the performance of the facilities and the transportation companies.

It is expected that expenditure growth will be slowed through a lower rate per trip, and by shifting utilization, where appropriate, from ambulette to livery services. The waiver may also result in improved quality of services, since the standards will be more specific and more stringent, the delivery of service will be monitored by HRA, and a client grievance system will be maintained. HCFA has requested further clarification of our proposal, and that application is also pending.

NEW YORK STATE'S POLICY ON FREEDOM OF CHOICE WAIVERS

Upon its enactment, New York State viewed Section 2175 of OBRA as offering a different approach to States to modify the delivery of health services toward greater efficiency. It seemed that beyond limiting who is eligible and what services are offered, States now had new options to influence recipient behavior. Freedom of choice is recognized, in principle, as a guarantee against a two class system of health services, and more specifically as a valuable protection of human dignity, and as having a profound effect on the practitioner/patient relationship. However, realities such as physician distribution, facility location, transportation problems, and organization and delivery patterns often negate the impact of freedom of choice.

The sudden appearance of a prohibition on a minimum enrollment period in Section 1902(m) of the Social Security Act was a minor problem so long as the Secretary had authority to waive it. Ironically, that, together with the enactment of TEFRA rescinding authority to waive provisions in 1903(m), closed a door that had previously been open to States.

An appropriate application of the provisions in Section 2175 requires knowledge of recipient utilization, provider referrals, variations in frequency of admissions and length of stay, and variations in per capita expenditures. The Statewide implementation of New York's Medicaid Management Information System had been completed in February, 1982, so it has only recently been possible to fully analyze recipient/provider behavior, and to predict with some certainty, the situations where limiting a recipient's freedom of choice might be cost-effective.

Recipients do not generally control the utilization or cost of institutional services such as acute inpatient hospital or residential health facility care, which represent approximately 75% of New York's total Medicaid expenditures. Although there are clearly some recipients who do misuse the health care system, large program costs and inefficiencies are not recipient generated. Preliminary reports suggest that the majority of Medicaid recipients utilize all health care services in moderation, and that few clients "shop" for services among providers.

Further, there are risks associated with implementing limitations on freedom of choice. In light of the above, New York has adopted four basic principles as a framework for review of proposals which may affect freedom of choice. They are:

1. The proposal must offer clients reasonable access to quality medical care, within a reasonable distance from their homes, at reasonable hours of the day.

2. The proposal must not unnecessarily disrupt clients or providers. Since the available data indicates that the majority of Medicaid clients see only one primary care provider during a year, the introduction of limitations for all clients, unless there are substantial benefits in health care or cost-effectiveness, is unnecessary and undesirable.

3. The proposal must be convincingly cost-effective. Since data indicates that most clients do not misuse Medicaid services, it does not appear that freedom of choice limitations alone will result in widespread changes in utilization. Changes in the health delivery system must be introduced if significant cost-effectiveness is to be achieved.

4. The proposal should encourage competition among health care providers. Competition among providers would foster cost efficiency, quality services, and greater access to care. Since utilization data show a substantial reliance on physician care, appropriate practitioners should be encouraged to participate.

SHORTCOMINGS OF SECTION 2175 FREEDOM OF CHOICE WAIVER

Like other states, New York is interested in program interventions which will facilitate cost containment and improve client access while simultaneously providing high quality medical care. Clearly, any interventions in the existing delivery system must be targeted to address aberrent or excessive patterns of care and/or expenditures. Logically, the thrust of any program aimed at client behavior would be to shift utilization of primary care providers to those generating low inpatient days; shifting ambulatory utilization, to the extent possible, from outpatient departments and emergency rooms to lower cost diagnostic and treatment centers and physicians; encouraging enrollment in prepayment plans; developing primary care case management plans; and pursuing opportunities for volume purchasing and competitive bidding for selected services.

New York's current administration has submitted proposals to the State legislature which would seek to accomplish these changes through a carefully planned, incremental approach, targeting reforms to the unique needs and strengths of local communities.

The flexibility provisions in Section 2175 of OBRA are insufficient to carry out the reforms seen as necessary in New York. At the same time, some of the changes permitted seem unnecessarily onerous to recipients. The new Section 1915 of the Social Security Act does not contain authority to permit the State to provide various enrollment incentives, including extended "guaranteed" eligibility and certain health and related social services to Medicaid recipients. Waivers required to assure that the State has flexibility in arranging benefit packages and reimbursement agreements with comprehensive health services organizations and primary care case managers cannot be granted under Section 1915.

Outside of a single demonstration project in western New York, the State is not interested in restricting the choice of recipients among providers. The State does, however, consider it important to require that, once Medicaid recipients have voluntarily elected to enroll with a state or federally certified HMO or physician case manager, they may be "locked-in" to that provider of choice for a period of six months following a thirty-day disenrollment period. It is also important for the State to be permitted to implement a case management system that restricts the provider from or through whom a recipient can obtain medical care and services. Such waivers are not possible under the 1915 authority.

Waivers are necessary to permit the State to enter into prepaid capitation arrangements for the purpose of providing comprehensive medical services to a predominantly public beneficiary population. This waiver cannot be granted under Section 1915.

The State will also require a waiver of 1903(m) to permit a physician case manager to provide hospital services directly or under contract; receive less than 25% of their gross revenue from non-Medicare and non-Medicaid patients; and receive more than a 20% increase in Medicaid revenue as a result of case management arrangements. These limitations were imposed in TEFRA, and the authority to grant waivers of 1903(m) was rescinded in that statute.

CONCLUSION

The concept of granting States the flexibility to develop innovative and cost-effective alternatives to the existing health care delivery system is a welcome change in a program which grew progressively more restrictive over the first fifteen years of its history. But the changes in the Omnibus Reconciliation Act of 1981, particularly after enactment of the 1982 Tax Equity and Fiscal Responsibility Act fell short of the flexibility needed in New York to make significant changes in the program.

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